IS THIS ANY WAY TO TREAT OUR TROOPS? PART III: TRANSITION DELAYS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, HOMELAND DEFENSE AND FOREIGN OPERATIONS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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IS THIS ANY WAY TO TREAT OUR TROOPS? PART III: TRANSITION DELAYS

WEDNESDAY, MAY 4, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, HOMELAND
DEFENSE AND FOREIGN OPERATIONS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m. in room 2154, Rayburn House Office Building, Hon. Jason Chaffetz (chairman of the subcommittee) presiding.

Present: Representatives Chaffetz, Labrador, Gosar, Farenthold, Tierney, Welch, Quigley.

Also present: Representatives Issa, Cummings, Buerkle.

Staff present: Thomas A. Alexander, senior counsel; Molly Boyl, parliamentarian; Kate Dunbar, staff assistant; Adam P. Fromm, director of Member liaison and floor operations; Erin Alexander, fellow; Jaron Bourke, minority director of administration; Kevin Corbin, minority staff assistant; Ashley Etienne, minority director of communications; Lucinda Lessley, minority policy director; Scott Lindsay, minority counsel; Zeita Merchant, minority LCDR, fellow; Dave Rapallo, minority staff director; and Donald Sherman and Carlos Uriarte, minority counsels.

Mr. CHAFFETZ. Welcome. The committee will please come to order.

I appreciate all of you being here on this important topic today, and I thank those participants in advance.

We want to welcome you to this hearing, which is entitled Is This Any Way to Treat our Troops? Part III, Transition Delays.

I would like to begin by thanking our military and intelligence community for their tireless efforts and heroism, as exemplified by the events of this past weekend. The fact that Osama bin Laden is no longer the leader of al Qaeda is a victory for the United States and those who stand against terrorism. A dark chapter in world history is now closed, but the fight is far from over.

I hope we all take time to pause in our own way and recognize the victims that have been at the hands of this tyrant, but also to thank the men and women who have served so tirelessly in the intelligence community, the military, the families that have poured their efforts to fight the war on terrorism. Undoubtedly, that will continue. But we need to thank them in our own way, in our own hearts and in our own communities.

As America redoubles its efforts to defeat global terrorism, let us never forget the brave men and women of our armed forces who

have brought us this far. They have sacrificed everything for us, and have for generations. Since 2001, 6,014 Americans have died in Operations Enduring Freedom, Iraqi Freedom, and New Dawn. Another 43,184 people have been injured during this time. In Afghanistan alone, these numbers have risen dramatically since our current President took office in 2009. You will see some charts here on the walls.

The total number of deaths has risen from 155 in 2008 to 499 in 2010. The total number of injuries has more than doubled, from 2,144 in 2008 to 5,226 in the year 2010. There have been 81 deaths and 854 injuries this year alone. Some wounds are visible and some are not, but were all acquired in the defense of our Nation and serving our country.

Just as our uniformed men and women took the oath to defend America, the Federal Government has a duty to provide care for them upon their return. Of the two, the Federal Government undeniably has the easier end of the equation. Yet we struggle to get it right. This is why we are here today.

The subcommittee will examine issues associated with the transition of wounded service members from the Department of Defense to the Department of Veterans Affairs. In recent years, various oversight bodies have identified significant shortcomings in the care and treatment of our veterans. These entities include the Government Accountability Office, the Independent Review Group commissioned by Defense Secretary Gates, Inspectors General, as well as the Dole-Shalala Commission. Each has highlighted deficiencies in the administrative processing of wounded service members.

A chief concern is the overly bureaucratic and lengthy disability evaluation system. The lack of seamless transition process is the source of great frustration for injured combat veterans and their families. Under the legacy Disability Evaluation System, often referred to as DES, service members wait an average, an average, of 540 days from the time they receive their medical evaluation from the Department of Defense to the time they receive a benefit check from the VA. Let me repeat that: 540 days. In some cases, this period is longer than the entire active duty enlistment.

According to reports, there are a number of reasons for this delay. These include duplicative medical exams, poor IT infrastructure, lack of staffing and others.

After much criticism, the Department agreed to revamp the DESs. In 2007, a pilot program called the Integrated Disability Evaluation system was introduced. This program aimed to consolidate programs and eliminate the gap in benefits. The goal is to reduce the 540 day process to 295 days. The average wait, according to a briefing by DOD and VA to committee staff is now 335 days. While 335 days is far more preferable than 540 days, it is still too long. Some of the old problems have yet to be resolved. GAO will describe some of those challenges here today. We appreciate them being here with us.

On March 17, 2011, Defense Secretary Gates and VA Secretary Shinseki agreed to examine ways to reduce the wait time to 75 to 150 days. They also agreed to devise an interagency electronic health information record. I am trouble it took until 2011 for these agreements to be reached. However, I do look forward to hearing

from our administration witnesses about how each department plans to achieve these goals.

With each new administration, there seems to be a renewed enthusiasm to address veterans issues. There is no doubt that the Department of Defense, the VA and this President are well-intentioned and have veterans' best interests at heart. We must ensure that the Federal Government is working smartly at each step of the way. With the recent increases in the number of deaths and injuries in Afghanistan, we have to get this right.

I look forward to hearing from our panel of witnesses about the successes and challenges they face. This subcommittee is ready to work with the Departments in whatever way possible to ensure the better care of our veterans.

At this time, I would like to recognize the ranking member of the full committee, Mr. Cummings, for 5 minutes.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I want to thank also our ranking member, who is on his way, Mr. Tierney, for convening this hearing today.

I too join you in saluting our troops, the CIA and all those people involved, and certainly too the President of the United States, Mr. Obama, for what was done over the last few days with regard to Osama bin Laden. I think it is quite appropriate, Mr. Chairman, that we sit here today addressing the issues confronting people like the Navy Seals, people like the young people who are right now at the U.S. Naval Academy in my State, and I serve on their board of visitors, who go out there, do their job, to protect our freedom, our rights, and protect our people. So I salute them and all those who are involved in that successful mission.

Last month, I visited Walter Reed, along with you, Mr. Chairman, and the Naval Medical Center, to meet with our wounded warriors and their caregivers. We talked with an Army sergeant who lost his legs in Laghman Province in Afghanistan, an Army captain who lost both legs and several fingers in eastern Afghanistan, and a young private from the Midwest who lost a leg and was there with his mother.

And these are very real costs of war. We owe our wounded warriors the very best health care when they return from the battlefield. For those of us sitting here, and those of you sitting at the witness table, it is our duty to make sure that the United States makes good on that promise. It is a very, very important promise.

I have often said that this is not, this must not be about politics. It must be about purpose. It must be about commitments that we have made to our men and women in uniform. When the Washington Post published a series of articles in 2007 detailing the appalling conditions at Walter Reed Army Medical center, I was angry and deeply embarrassed by the poor quality of care, the terrible conditions and the bureaucratic obstacles facing our service members and veterans.

In the previous Congress, this committee has taken an active role in holding DOD and VA responsible for improving the care of our wounded warriors. Representative Tierney, to his credit, held the very first hearing on this issue in the 110th Congress. Back then, I wasn't even on this subcommittee, but I appeared with him

at his first committee hearing on that, subcommittee hearing on that, at Walter Reed.

And Chairman Chaffetz, by holding today's hearing, you are demonstrating your commitment to continuing our committee's bipartisan commitment to this cause. This is a situation where Republicans and Democrats must not move to common ground, we must move to higher ground.

As a result of these vigorous oversight efforts, the Dole-Shalala Commission was created to assess longstanding health care and disability evaluation issues within DOD and VA. A joint DOD-VA senior oversight committee was also established to implement many of the recommendations made by the Dole-Shalala Commission. One of those recommendations, to improve the military's complicated and time-consuming disability evaluation system, is in the process of being fully implemented nationwide. I have one word for all of those at the witness table: we must move with all deliberate speed. Our veterans and our servicepeople cannot wait.

I am encouraged that the new Integrated Disability Evaluation System has simplified the process for our wounded warriors and reduced the time it takes for veterans to get their full benefits. I am proud to say that when the IDES process is fully implemented, it will effectively eliminate the benefit gap faced by our newly minted veterans.

But the process is still too time-consuming. We can do better. Our service members should not have to wait over a year to determine whether they are fit to continue their military service and the level of benefits they will receive if they are discharged. Even if DOD and VA were meeting their goal of completing the IDES process in 295 days, nearly 10 months is simply too long for our service members to wait while their future hangs in the balance. And by the way, their families are also affected greatly.

DOD and VA must also do more to improve the exchange of medical records, given the complicated health conditions facing many of our service members when they leave Iraq or Afghanistan. It is vitally important therefore that the health care providers of these two departments communicate seamlessly. As I close, I know that DOD and VA are in the process of creating the interagency electronic medical records and I look forward to hearing more about the progress today.

With that, again, Mr. Chairman, I thank you for calling this hearing and I yield back.

Mr. CHAFFETZ. Thank you. The gentleman yields back.

I now recognize the chairman of the full committee, Mr. Issa of California.

Mr. ISSA. Thank you, Mr. Chairman. It is a distinct honor to go after the ranking member, so that I can say I agree with everything the ranking member said. This is an issue that goes beyond partisanship. This is an issue in which the committee is completely united.

I am honored to have Camp Pendleton in my district, and the Wounded Warrior facility that is there. There is no distance between Mr. Cummings and myself. I sometimes do see that there are reasons that we have 10 months or more in which a marine continues to try, or a corpsman, to return to full active duty and

is working through that. But with the exception of those times in which you are clearly trying to help a soldier, sailor, marine or airman remain on active duty and that extends the determination, I do believe that the process is too slow and continues to be, we can do better but we haven't yet done it.

So again, I thank the chairman for holding this hearing, and I thank Mr. Cummings for his appropriate remarks, and yield back.

Mr. CHAFFETZ. The gentleman yields back.

Members will have 7 days to submit further opening statements for the record.

We will now recognize our panel. Ms. Lynn Simpson is the Acting Principal Deputy Undersecretary of Defense for Personnel and Readiness. Mr. John Medve is the Executive Director of the VA/DOD Collaboration Service. Mr. Dan Bertoni is the Education, Workforce and Income Security Team Director at the GAO. Mr. Randall Williamson is the Health Care Team Director at the GAO. And Mr. Mark Bird is the IT Team Assistant Director at the Government Accountability Office.

We appreciate you all being here today. My understanding is that the GAO is going to submit one opening statement, but they will all participate in the discussion that we have moving forward.

Pursuant to committee rules, all witnesses will be sworn in before they testify. If you would please rise and raise your right hands.

[Witnesses sworn.]

Mr. CHAFFETZ. Thank you. You may be seated.

Let the record reflect that all the witnesses answered in the affirmative.

In order to allow time for discussion, please try to limit your verbal testimony to 5 minutes. If there are additional materials or statements that you want to put into the record, your entire written statement will be made a part of the record.

I again want to thank you for your time, effort, your expertise, your commitment to our country. I know your hearts are all in the right places. This is a frustrating issue for the time that it has taken. But we do want to hear from each of you.

So with that, we will now recognize Ms. Simpson for 5 minutes.

STATEMENTS OF LYNN SIMPSON, ACTING PRINCIPAL DEPUTY UNDERSECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE; JOHN MEDVE, EXECUTIVE DIRECTOR, VA/DOD COLLABORATION SERVICE, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE AND INCOME SECURITY, U.S. GOVERNMENT ACCOUNTABILITY OFFICE, ACCOMPANIED BY RANDALL B. WILLIAMSON, HEALTH CARE TEAM DIRECTOR, USGAO, AND MARK BIRD, IT TEAM ASSISTANT DIRECTOR, USGAO

STATEMENT OF LYNN SIMPSON

Ms. SIMPSON. Thank you, Mr. Chairman.

Representative Chaffetz, Representative Tierney, members of the subcommittee, thank you very much and good morning.

Thank you for the opportunity and the privilege to testify today on our warriors in transition with my colleague from the VA, John Medve.

Taking care of our wounded, ill and injured service members is one of the absolute highest priorities of the Department of Defense, the service Secretaries and the military chiefs. The Secretary of Defense has said that, other than directly supporting operations in theater, there is no higher priority for the Department of Defense.

Reforming cumbersome and many times confusing bureaucratic processes is absolutely essential to ensuring our service members receive, in a timely manner, the care and benefits to which they are entitled. The Department's leaders continue to work to achieve the highest level of care and management and to standardize care among the military services and Federal agencies, while maintaining a laser focus on the wide range of needs of our wounded, ill and injured service members and their families.

Working closely, carefully and collaboratively between our departments is also of the upmost priority. We have established governance at the highest levels of our respective departments on the wounded, ill and injured issues. The Secretaries of the Departments of Defense and Veterans Affairs have met three times in the last 90 days with an increased attention on the Disability Evaluation System and electronic health records and have committed also to meet quarterly to continue the dialog to resolve these critical areas of collaboration between our departments.

The Secretary of Defense had directed the establishment of the Department of Defense, Department of Veterans Affairs, Senior Oversight Committee, referred to as the SOC, on May 3, 2007. It was established to ensure that recommendations from the groups that many of you referenced were integrated, implemented and resourced. The Senior Oversight Committee's purpose is to ensure interagency oversight to streamline, deconflict and expedite efforts to improve the health care process, disability processing and the seamless transition of service member to veteran status. The Deputy Secretaries of both Departments serve as co-chairs.

The overarching purpose of the Senior Oversight Committee is to establish a world class, seamless continuum of care that is efficient and effective. The SOC has had a lengthy record of accomplishments over its 4 years of existence in direct support of and caring for our wounded, ill and injured. I want to offer a few of the accomplishment highlights: reducing the gap in time service members receive veterans' benefits after separation; developing new approaches to address psychological health, to include traumatic brain injury and post-traumatic stress; expanding the implementation of the Integrated Disability Evaluation System; providing transitioning service members' health records to the VA prior to their separation from military service; and implementing the recovery care coordination program, highlighting the need to address caregiver issues to ensure that they receive support and information.

The Disability Evaluation System was relatively unchanged from 1949 until 2007. As a result of Secretary-level attention, public concern and congressional interest, the Senior Oversight Committee chartered the DES pilot in November 2007. The SOC vision for this

pilot was to create a service member-centric, seamless and transparent DES, administered jointly by the DOD and VA.

The pilot transitioned to the Integrated Disability Evaluation System that integrates DOD and VA DES processes, so that the service member receives a single set of the physical disability evaluations and disability ratings, conducted and prepared by the Veterans Affairs office, with simultaneous processing by both departments to ensure the earliest possible delivery of disability benefits. Both departments use the VA protocols for disability examinations and the VA disability rating to make their respective determinations.

The Department of Defense is partnering closely with the Department of Veterans Affairs as we aggressively move toward the full implementation of the IDES across all 139 continental United States and outside the continental United States by the end of this fiscal year. The IDES constitutes a major improvement over the legacy system and both DOD and VA are fully committed to the worldwide expansion of this program.

The Department is, however, continuously exploring new ways to improve the current system. Because as long as one service member is in the system longer than perceived helpful, we are obligated and committed to do all we can to enhance the experience and make improvements. To that end, the Secretaries of Defense and Veterans Affairs have asked the teams to explore other options which could shorten the overall length of the disability evaluation process from its current goal of 295 days.

In addition, the Departments are also looking closely at the stages of the Disability Evaluation System that are outside the timeliness tolerances, and developing options to bring these stages within the goal. We are committed to do all we can within our areas of influence to enhance the experience and process and will be sure to keep the Congress informed of this progress along the way, and as new initiatives are identified that can further advance the efficiency and effectiveness of the disability evaluation process.

Another highlight from the Senior Oversight Committee that drove to significant enhancement involves the attention to the caregiver.

Mr. CHAFFETZ. Perhaps if we could submit the balance of that testimony, so that we have time to get to the full panel.

Ms. SIMPSON. I will jump to the end of my last paragraph that summarizes what I have been trying to say to you this morning. Thank you.

Mr. Chairman and subcommittee members, I cannot overstate how far DOD has come with our VA partners in the past 4 years, since the SOC and other governance processes were put in place. Our support for our wounded, ill and injured is night and day from the events that occurred at Walter Reed in 2007. Each of the services has stood up a very comprehensive and standalone warrior care program, as many of you are aware and have visited here and in your districts.

Yet we still have much progress to make. As I close, I would like to be articulate, again, that one mistake, mistreatment, undue delay or any other aberration in the care or transition of our wounded, ill or injured service members is one too many. We will

continue to work with our teammates at VA and throughout the interagency to do anything and everything we can to provide our service members with the absolute best care and treatment that they so rightfully deserve in return for their selfless service and sacrifice to our Nation.

Thank you again for the opportunity.

[The prepared statement of Ms. Simpson follows:]

Prepared Statement

of

Ms. Lynn Simpson
Chief of Staff
OUSD Personnel & Readiness

Before the

Subcommittee on National Security, Homeland Defense, and Foreign Operations
House Oversight and Government Reform Committee

May 4, 2011

Chairman Chaffetz, Ranking member Tierney, and members of this distinguished Subcommittee, thank you for inviting us to testify before you on the care and transition of our wounded warriors from the Department of Defense to the Department of Veterans Affairs. Taking care of our wounded, ill and injured Service members is one of the highest priorities of the Department, the Service Secretaries and the Service Chiefs. The Secretary of Defense has said, other than the War itself, there is no higher priority. Reforming cumbersome and sometime confusing bureaucratic processes is crucial to ensuring Service members receive, in a timely manner, the care and benefits to which they are entitled. The Department's leaders continue to work to achieve the highest level of care and management and to standardize care among the Military Services and Federal agencies, while maintaining focus on the individual.

Senior Oversight Committee (SOC)

The Secretary of Defense established the Department of Defense/Department of Veterans Affairs Senior Oversight Committee (SOC) on May 3, 2007, to ensure recommendations from the Independent Review Group and the President's Commission on Care for America's Returning Wounded Warriors were promptly integrated, implemented, and resourced. Later, recommendations and requirements of the Task Force on Returning Global War on Terror Heroes, the DoD Task Force on Mental Health, the Veterans' Disability Benefits Commission, and the FY2008 and FY2009 National Defense Authorization Acts were also incorporated. The Senior Oversight Committee's purpose is to ensure inter-agency oversight to streamline, de-conflict, and expedite efforts to improve the health care process, disability processing, and the seamless transition from Service member to Veteran status. The Deputy Secretaries from the Departments of Defense and Veterans Affairs serve as committee co-chairs.

The overarching purpose of the Senior Oversight Committee is to establish a world-class, seamless continuum of care that is efficient and effective. Its membership includes senior DoD, VA, and military Service representatives. A supporting Overarching Integrated Product Team (OIPT) of joint interagency senior leadership coordinates, integrates, and synchronizes the Committee work, agenda and actions. Given the magnitude of the issues addressed and the complexity of integrating the recommendations, the SOC created the Wounded, Ill, and Injured

Senior Oversight Committee (WII SOC) Staff Office. The Staff Office provides assistance, advice, and expertise to facilitate changes to policies, procedures, and legislation in order to effectively institute program and process enhancements related to the recovery, rehabilitation, and reintegration of our wounded, ill and injured Service members, veterans, and their eligible beneficiaries.

To date, the SOC has accomplished the following in support of care for wounded warriors:

- The integration of DoD and VA into a single team.
- The implementation of new approaches to support patients and their families and/or caregivers.
- The development of new approaches to address psychological health, to include Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).
- The worldwide expansion of the Integrated Disability Evaluation System.
- Integrated Mental Health Strategy.
- The increased sharing of health information between DoD and VA.
- Significant improvement customer care delivery.

The two Departments and the SOC are actively implementing more than 500 recommendations from six major studies, and the FY 2008 and FY 2009 National Defense Authorization Acts. The implementation is taking place through eight lines of action (LoAs), as follows:

- LoA 1 (Disability Evaluation System) developed and implemented a Disability Evaluation System Pilot aimed toward streamlining the DoD disability evaluation system with assistance from VA. Worldwide expansion of an Integrated Disability System is currently underway.
- LoA 2 (Traumatic Brain Injury and Post Traumatic Stress Disorder) efforts brought psychological health issues to the forefront, in an effort to treat and dispel the stigma associated with seeking treatment for TBI and PTSD.
- LoA 3 (Case Management) coordinated health care, rehabilitation, and delivery of services that resulted in facilitating the highest level of support ever provided to the wounded, ill, and injured.
- LoA 4 (Information Technology) increased data sharing of essential health information between the DoD and VA. (Examples: Electronic Health Record (EHR) initiative and e-Benefit portal).
- LoA 5 (Facilities) inspected and improved all Military medical facilities and housing used by the wounded, ill, and injured and their families.

- LoA 6 (Clean Sheet Review) initiated actions to provide WII personnel and their families the best quality care with compassionate, fair, timely, and non-adversarial processes.
- LoA 7 (Comprehensive Legislation and Public Affairs) kept Service members, veterans, family members, the public, DoD/VA leadership, and Congress informed of new developments in care. Legislative language was introduced, as needed.
- LoA 8 (Personnel, Pay, and Financial Support) studied and developed pay and entitlement programs for Service members, Veterans, their families and their caregivers.

Continued efforts will focus on four main areas:

- Service accomplishments.
- Continuity of Care initiatives for DoD and VA to form a coordinated team approach.
- The new approach to psychological health and the anti-stigma campaign for Traumatic Brain Injury and Post Traumatic Stress Disorder.
- The revolution in customer care.

These initiatives are the core of current and future efforts to provide our wounded, ill, and injured Service members, Veterans, and family members the care and benefits they have deservedly earned. To this end, DoD and VA are making progress in key areas of weakness as identified by the SOC and the LoAs. Below specifies our major efforts to provide better transition and care of our wounded, ill and injured Service members.

Disability Evaluation System/Integrated Disability Evaluation System

The genesis of the Disability Evaluation System (DES) is the Career Compensation Act of 1949. The DES was relatively unchanged until 2007. As a result of public concern and congressional interest, the Senior Oversight Committee chartered the DES Pilot in November 2007. The SOC vision for the DES Pilot was to create a "Service Member Centric" seamless and transparent DES, administered jointly by the DoD and VA.

DoD and VA launched the DES Pilot at the three major military treatment facilities (Walter Reed, Bethesda, and Malcolm Grow) in the National Capital Region (NCR) on November 21, 2007. The DES Pilot successfully streamlined the DoD disability system with assistance from VA, and as a result, DoD and VA benefits are delivered to wounded, ill and injured Service members and to veterans as soon as legally possible. DoD and VA found the integrated DES to be a faster, fairer, more efficient system and, as a result, the SOC Co-chairs

(Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs) on July 30, 2010, directed worldwide implementation of the process beginning in October 2010 to be completed at the end of September 2011. On December 31, 2010, the first Integrated Disability Evaluation System (IDES) site became operational, which marked the end of the pilot, and the name was formally changed to the IDES.

The IDES, similar to the pilot, provides a process in which the member receives a single set of physical disability examinations conducted according to VA examination protocols, proposed disability ratings prepared by VA, and simultaneous processing by both Departments to ensure the earliest possible delivery of disability benefits. Both Departments use the VA protocols for disability examination and the proposed VA disability rating to make their respective determinations. DoD determines fitness for duty and compensates for unfit conditions incurred in the line of duty (Title 10), while VA compensates for all disabilities incurred or aggravated in line of duty during military, naval, or air service for which a disability rating of 10 percent or higher is awarded and thus may establish eligibility for other VA benefits and services (Title 38). The IDES requires the Departments to complete their disability determinations before DoD separates a Service member so that both Departments can provide disability benefits at the earliest point allowed under both titles. Service members who separate or retire (non-disability) may still apply to the VA for service-connected disability compensation.

In summary, the IDES features a Service member-centric design, simpler, faster and more consistent evaluations and compensation, single set of disability exams and proposed disability rating, seamless transition to Veteran status, disability case management advocacy, and establishment of a Service member relationship with the VA prior to separation. It also provides increased transparency through better information flow to Service members and their family and a reduced gap between separation/retirement from Service to receipt of VA benefits. Active component members completed the program 37 percent faster than a sample of legacy DES cases. As of April 11, 2011, cumulative IDES enrollment is 21,328 Service members with 6,893 completing the program by medical separation, retirement, or return to duty.

The Department of Defense is partnering closely with the Department of Veterans Affairs as we aggressively move toward IDES implementation at all 139 CONUS and OCONUS sites by 30 September 2011.

The impact of each stage of the IDES expansion and cumulative DES population is shown below:

- Stage I-West Coast & Southeast (October-December 2010) - (Completed) 58%
- Stage II-Rocky Mountain & Southwest Region (January-March 2011) – (Completed) 73%
- Stage III-Midwest & Northeast (April - June 2011) - 90%
- Stage IV-Outside Continental United States (OCONUS)/CONUS (July – September 2011) -- 100%

IDES constitutes a major improvement over the legacy DES and both DoD and VA are fully committed to the worldwide expansion of IDES. The Department is, however, continuously exploring new ways to improve the current system. The Secretaries of Defense and Veterans Affairs are currently exploring several options to shorten the overall length of the disability evaluation process from its current goal of 295 calendar days. In addition, the Departments are also looking closely at the stages of the disability evaluation system that are outside of timeliness tolerances and developing options to bring these stages within goal. We are committed to working closely with Congress in exploring new initiatives that can further advance the efficiency and effectiveness of the disability evaluation process.

Recovery Coordination Program

The DoD Recovery Coordination Program (RCP) was established by Section 1611 of the FY2008 National Defense Authorization Act. This mandate called for a comprehensive policy on the care and management of covered Service members, including the development of comprehensive recovery plans, and the assignment of a Recovery Care Coordinator for each recovering Service member. In December 2009, a Department of Defense Instruction (DoDI 1300.24) set policy standardizing non-medical care provided to wounded, ill and injured Service members across the military departments. The roles and responsibilities captured in the DoDI are as follows:

- **Recovery Care Coordinator**: The Recovery Care Coordinator (RCC) supports eligible Service members by ensuring their non-medical needs are met along the road to recovery.
- **Comprehensive Recovery Plan**: The RCC has primary responsibility for making sure the Recovery Plan is complete, including establishing actions and points of contact to meet the Service member's and family's goals. The RCC works with the Commander to oversee and coordinate services and resources identified in the Comprehensive Recovery Plan (CRP).
- **Recovery Team:** The Recovery Team includes the recovering Service member's Commander, the RCC and, when appropriate, the Federal Recovery Coordinator (FRC), for catastrophically wounded, ill or injured Service members, Medical Care Case Manager and Non-Medical Care Manager. The Recovery Team jointly develops the CRP, evaluating its effectiveness and adjusting it as transitions occur.
- **Reserve/Guard**: The policy establishes the guidelines that ensure qualified Reserve Component recovering Service members receive the support of an RCC.

There are currently 146 DoD trained RCCs in 67 locations placed within the Army, Navy, Marines, Air Force, United States Special Operations Command (USSOCOM) and Army Reserves. Care Coordinators are hired and jointly trained by DoD and the Services' Wounded Warrior Programs. Once placed, they are assigned and supervised by Wounded Warrior Programs but have reach-back support, as needed, for resources within the Office of Wounded Warrior Care and Transition Policy. DoD RCCs work closely with FRCs as members of a Service member's recovery team.

In the DoDI, we have codified that severely injured and ill who are highly unlikely to return to duty and will most likely be medically separated from the military (Category 3) will also be assigned an FRC. The DoDI 1300.24 establishes clear rules of engagement for RCCs. The RCC's main focus is on Service members who will be classified as Category II. A Category II Service member has a serious injury/illness and is unlikely to return to duty within a time specified by his or her Military department and may be medically separated. The FRC's main focus is on the Service members who are classified as Category III. A Category III Service member has a severe or catastrophic injury/illness and is unlikely to return to duty and is likely to be medically separated.

While defined in the DoDI, Category I, II and III are all administrative in nature and have been difficult to operationalize. The intent of the controlling DoDI is to ensure that wounded, ill, and injured Service members receive the right level of non-medical care and coordination. DoD is working with the FRCP to make sure that Service members who need the level of clinical and non-clinical care coordination provided by a FRC are appropriately referred.

Earlier this year, the Senior Oversight Committee (SOC) directed RCP and the Federal Recovery Coordination Program (FRCP) leadership to establish a DoD-VA Executive Committee on Care/Case Management/Coordination to identify ways to better coordinate the efforts of FRCs and RCCs and resolve issues of duplicative or overlapping case management. The Committee conducted its first meeting in March and its final two-day meeting will be held on May 10 – 11. The results of the Committee's efforts will be briefed to the SOC at its June meeting.

In March 2011, DoD also conducted an intense 2 ½ day Wounded Warrior Care Coordination Summit that included focused working groups attended by subject matter experts who discussed and recommended enhancements to various strategic wounded warrior issues requiring attention. One working group focused entirely on collaboration between VA and DoD care coordination programs. Another group focused on best practices within recovery care coordination and a third group focused on wounded warrior family resiliency, employment and education. Actionable recommendations are currently being reviewed, have been presented to the Overarching Integrated Product Team (OIPT) and will continue to be worked until approved recommendations and policies are implemented.

DoD is committed to working closely with the Federal Recovery Coordination Program leadership to ensure a collaborative relationship exists between the DoD RCP and the FRCP. The Military Department Wounded Warrior Programs will also continue to work closely with FRC's in support of Service members and their families.

Transition Assistance Program (TAP)

To strengthen our Transition Assistance Program (TAP) and reinforce its value to Service members and their families, the Department, in collaboration with our partners at the

Departments of Veterans Affairs (VA) and Labor (DOL), is committed to moving TAP from a traditional event-driven approach to a modern, innovative lifecycle approach. We are shifting from an end of military life-cycle event to an outcome based model that will measure success not only on the number of Service members who use the TAP process, but also on the number of transitioning service members and their families who find the TAP process beneficial in assisting them with their life goals, military career progression, and/or new careers/meaningful employment outside of uniformed service. We will be implementing this strategic plan with focuses on information technology, strategic communications, and resources and performance management. The end-state for the TAP overhaul will be a population of Service members who have the knowledge, skills, and abilities to empower themselves to make informed career decisions, be competitive in the global work force and become positive contributors to their community as they transition from military to civilian life.

As part of this effort, we launched the DoD Career Decision Toolkit in August 2010. The Toolkit was developed in collaboration with the Military Services and our TAP partners at the Department of Veterans Affairs and Department of Labor to help simplify the learning curve for transitioning Service members with the information, tools, and resources they need to succeed in the next phase of their lives. The toolkit uses the latest technology to consolidate the very best teaching materials from all the Service branches and provides thousands of on-demand resources to Service members. It is interactive, simple to use and portable. The toolkit includes:

- More than 3,000 on-demand information and planning resources
- Transition subjects such as career exploration, financial planning, resume creation, interviewing skills and compensation negotiation
- Tools that enable Service members to catalogue their military skills, training, and experience in ways that transfer to civilian sector
- Post-Service benefits and resources
- Resources that allow users to self-assess individual transition needs and plan personalized options

We are developing an "end-to-end" virtual TAP delivery vehicle delivery platform that will provide the back-bone of the transformed TAP program, integrating the Guard and reserve components, as well as expanding services available to family members.

DoD has also played a supporting role with the Office of Personnel Management on the initiative to increase hiring veterans in all federal agencies. This is now recognized as President Obama's Veterans Employment Initiative that directs all Executive Agencies to increase veteran employment. TAP is one of the programs we will use to educate and inform Service members about federal Service career opportunities.

Interagency Electronic Health Data

The collaborative Federal partnership between DoD and VA has resulted in increased integration of healthcare services to Service members and Veterans. DoD and VA spearhead numerous interagency electronic health data sharing activities and are delivering IT solutions that significantly improve the secure sharing of appropriate electronic health information.

Today's interagency health information exchange (HIE) capabilities leverage the existing electronic health records (EHRs) of each Department. Both Departments are currently addressing the need to modernize their EHRs. We are working together to synchronize EHR planning activities and identify a joint approach to EHR modernization.

Current HIE sharing capabilities support electronic health data sharing between DoD and VA. The Federal Health Information Exchange (FHIE), Bidirectional Health Information Exchange (BHIE), and the Clinical Data Repository/Health Data Repository (CHDR) support continuity of care for millions of Service members and Veterans by facilitating the sharing of health care data as beneficiaries move beyond DoD direct care to the VA. The data shared includes information from DoD's inpatient documentation system which is in use in DoD's inpatient military treatment facilities, including Landstuhl Regional Medical Center, Germany, the evacuation and treatment center Service members pass through if they have a medical problem while deployed in the current theater of operations. The health data shared assists in continuity of care and influences decision making at the point of care.

Transmission of Data from Point of Separation: At separation, the Federal Health Information Exchange (FHIE) provides for the one-way electronic exchange of historic healthcare information from DoD to VA for separated Service members since 2001. On a monthly basis

DoD sends: laboratory results; radiology reports; outpatient pharmacy data; allergy information; discharge summaries; consult reports; admission/discharge/transfer information; standard ambulatory data records; demographic data; pre- and post-deployment health assessments (PPDHAs); and post-deployment health reassessments (PDHRAs). DoD has transmitted health data on more than 5.6 million retired or separated Service members to VA. Of these 5.6 million patients approximately 2.1 million have presented to VA for care, treatment, or claims determination. This number grows as health information on recently separated Service members is extracted and transferred to VA monthly.

Access to Data on Shared Patients: For shared patients being treated by both DoD and VA, the Departments maintain the jointly developed Bidirectional Health Information Exchange (BHIE) system that was implemented in 2004. Unlike FHIE, which provides a one-way transfer of information to VA when a service member separates from the military, the two-way BHIE interface allows clinicians in both Departments to view, in real-time, health data (in text form) from the Departments' existing health information systems. Accessible data types include allergy, outpatient pharmacy, inpatient and outpatient laboratory and radiology reports, demographic data, diagnoses, vital signs, problem lists, family history, social history, other history, questionnaires and Theater clinical data, including inpatient notes, outpatient encounters and ancillary clinical data, such as pharmacy data, allergies, laboratory results and radiology reports.

Use of BHIE continues to increase. The number of patients, including Theater patients, available through BHIE increased during FY 2010 by approximately 400,000 shared patients. There are more than 4.0 million shared patients including health data for over 243,000 Theater patients, available through BHIE.

To increase the availability of clinical information on a shared patient population, VA and DoD collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD's IDS. Use of the IDS at Landstuhl Regional Medical Center plays a critical role in ensuring continuity of care and supporting the capture and transfer of inpatient records of care for wounded warriors. Information from these records is accessible

stateside to DoD providers caring for injured Service members and inpatient discharge summaries are available to VA providers caring for injured Service members and Veterans. As of April 2011, discharge summaries are available for all DoD inpatient beds. IDS is now operational at all 59 DoD inpatient sites.

Recent improvements to BHIE include the completion of hardware, operating system, architecture, and security upgrades supporting the BHIE framework and its production environment. This technology refresh, completed in January 2011, resulted in improved system performance, and reliability.

Exchange of Pharmacy and Allergy Data: The Clinical Data Repository/Health Data Repository (CHDR) supports interoperability between AHLTA's CDR and VA's HDR, enabling bidirectional sharing of standardized, computable outpatient pharmacy and medication allergy data. Since 2006, VA and DoD have been sharing computable outpatient pharmacy and medication allergy data through the CHDR interface. Exchanging standardized pharmacy and medication allergy data on patients supports improved patient care and safety through the ability to conduct drug-drug and drug-allergy interaction checks using data from both systems.

In FY 2010, the Departments exchanged computable outpatient pharmacy and medication allergy data on over 250,000 patients who receive healthcare from both systems. This was a more than 400 percent increase from the 44,000 patients whose computable pharmacy and medication allergy data was being exchanged in FY 2009. By the second quarter of FY 2011 the Departments have exchanged computable outpatient pharmacy and medication allergy data on over 741,000 patients who receive healthcare from both systems.

Wounded Warrior Image Transfer: To support our most severely wounded and injured Service members transferring to VA Polytrauma Rehabilitation Centers for care, DoD sends radiology images and scanned paper medical records electronically to the VA Polytrauma Rehabilitation Centers. Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Brooke Army Medical Center are providing scanned records and radiology images electronically for patients transferring to VA Polytrauma Rehabilitation Centers in Tampa, Richmond, Palo

Alto, and Minneapolis. From 2007 to the present, images for more than 375 patients and scanned records for more than 470 severely wounded warriors have been sent from DoD to VA at the time of referral.

Virtual Lifetime Electronic Record: The Departments are firmly focused on enhancing our electronic health data sharing and expanding capabilities to share information with the private sector through Nationwide Health Information Network (NwHIN) and the Virtual Lifetime Electronic Record (VLER). NwHIN will enable the Departments to view a beneficiary's healthcare information not only from DoD and VA, but also from other NwHIN participants. To create a virtual healthcare record—and achieve the VLER vision—data will be pulled from EHRs and exchanged using data sharing standards and standard document formats. A standards based approach will not only improve the long-term viability of how information is shared between the Departments, but will also enable the meaningful exchange of information with other government providers and with civilian providers, both of which account for a significant portion of care delivered to the Departments' beneficiaries.

The VLER pilot projects are demonstrations of exchanges of electronic health information between VA, DoD and participating private sector providers. The pilots continue to provide evidence of the power and effectiveness of coordinated development between the Departments for increasing the secure sharing of electronic health information while leveraging existing EHR capabilities. DoD's VLER pilots are underway in San Diego, California; Tidewater, Virginia; and Spokane, Washington. The fourth and final pilot will be launched in Puget Sound, Washington in late FY 2011. In addition, VA is participating in seven other pilots with the private sector to expand the VLER capability. Those pilots are in Asheville, NC, Richmond, VA, Rural Utah, Indianapolis, IN and three other sites that have not yet been publicly announced. By September 2011, VA will be operational in a total of 11 pilot sites, with at least 50,000 Veterans participating who have provided written consent to share records with the private sector.

Modernizing the EHR – The Foundation for Interagency Data Sharing: The Departments are collaborating on a common framework and approach to modernize our EHR applications.

The Secretary of Defense and Secretary of Veterans Affairs affirmed we will continue to synchronize our EHR planning activities to accommodate the rapid evolution of healthcare practices and data sharing needs, and to speed fielding of new capabilities. The Departments have already identified many synergies and common business processes, including common data standards and data center consolidation, common clinical applications and a common user interface. VA is evaluating open source management options, and DoD is working with the VA to identify opportunities to contribute and participate in the open source collaboration. As the open source communities mature, DoD and VA will continue to analyze open source components that fit the architectural construct for use in the future EHR.

World-Class Medical Care in the National Capital Region

The Base Realignment and Closure (BRAC) construction projects at Bethesda and Fort Belvoir will provide nearly three million square-feet of new world-class clinical and administrative space, cutting-edge technology, and Americans with Disability Act lodging to meet the rehabilitation needs of Wounded, Ill, and Injured service members. The new facilities will improve the infrastructure for casualty care and services and better align healthcare delivery with the population centers of the National Capital Region (NCR) beneficiaries. The projects are on schedule to receive patients and clinical functions from Walter Reed Army Medical Center (WRAMC) by September 15, 2011, while casualty care and patient safety remain the top priorities related to the move. The majority of the BRAC construction at both sites is complete and patient care is being provided in the new inpatient and outpatient pavilions at Bethesda. The Department is paying close attention to the timeliness and milestones necessary to achieve the final moves.

The BRAC projects are only part of the larger transformation of Military Medicine in the NCR. The NCR contains a mix of nearly 40 Army, Navy, and Air Force Medical Treatment Facilities (MTFs), has almost 550,000 eligible beneficiaries, and runs on an annual operating budget of almost $1.5 Billion. Its most important patients are the casualties returning from the war and their families. The Department is taking the opportunity to substantially enhance and transform this multi-Service military healthcare market to provide effective and efficient world-class healthcare. The Joint Task Force National Capital Region Medical (JTF CapMed) is a

standing JTF that was established to oversee the rationalization and realignment of medical infrastructure to achieve greater effectiveness and cost efficiency through the integrated delivery of healthcare.

DoD's Comprehensive Master Plan (CMP) for the NCR, provided to Congress last year, outlined how JTF CapMed will implement an Integrated Healthcare Delivery System (IDS) to provide this world-class healthcare cost effectively. The Department has provided JTF CapMed with command and fiduciary authorities to manage MTFs in the NCR and directed that the new hospitals at Bethesda and Fort Belvoir become joint commands subordinate to JTF CapMed to develop best practices, enhance interoperability and patient safety, and combine shared services such as contracting, personnel, and consolidated information technology – ultimately improving the *patient and family experience*. An example of clinical transformation is in the direct care pharmacy system that will facilitate prescriptions and refills no matter where in the NCR they are presented, provide refills to Six Sigma quality standards, and alleviate traffic concerns at NCR BRAC sites.

The Department has requested $109M in the President's 2012 budget ($762M between FY12 - FY16) to recapitalize medical facilities at Bethesda that the BRAC did not address and provide the new space required to convert to single patient rooms and expand support for the operating suites. These facility projects and the implementation of the NCR IDS by JTF CapMed are part of the Department's commitment to providing "world-class" healthcare in the NCR and fulfilling the requirements under section 2714 of the FY10 NDAA.

Conclusion

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless service members, veterans and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Mr. Chairman, thank you again for your generous support of our wounded, ill, and injured service members, veterans and their families. I look forward to your questions.

Mr. CHAFFETZ. Thank you.

Mr. Medve, we will now recognize you for 5 minutes.

STATEMENT OF JOHN MEDVE

Mr. MEDVE. Thank you, Mr. Chairman.

Mr. Chairman, Ranking Member Cummings and members of the subcommittee, good morning and thank you for the opportunity to testify before you today.

My name is John Medve, Executive Director of the Department of Veterans Affairs/Department of Defense Collaboration Service for VA's Office of Policy and Planning. I am pleased to be joined by the chief of staff from the Undersecretary of Defense Office of Personnel and Readiness, Lynn Simpson.

I would like to provide the subcommittee with an overview of collaboration between the VA and DOD to ensure a seamless transition of our wounded, ill and injured service members from active duty to veteran status. I ask that my complete statement be included in the record.

Much has been accomplished in the wake of the problems identified at the Walter Reed Army Medical Center in 2007 to improve the DOD disability process and the resulting transition to veteran status. The focus of my testimony is VA and DOD's joint efforts to make the improvements and to create an integrated disability process for service members who are being medically separated.

Currently we are in the process of implementing the Integrated Disability Evaluation System, the process used to transition the wounded, ill and injured who are unfit for continued service from service member to veteran. In early 2007, VA partnered with DOD to make changes to the DOD's existing DES. A modified process called VA/DOD DES pilot was launched in November 2007. The DES pilot was intended to simplify the disability process, increase the transparency, reduce the processing time and improve the consistency of the disability ratings among the services and between the services and VA. Authorization for the pilot was included in the National Defense Authorization Act of 2008, and further energized our efforts for improving DOD's DES process.

The DES pilot model was launched originally at three operational sites in the National Capital region and recognized a significant improvement over the legacy process. The pilot model was subsequently expended in 2008 and 2009, ultimately covering 27 sites and 47 percent of the DES population when ended in March 2010.

In July 2010, the co-chairs of the Senior Oversight Committee agreed to expand the pilot and rename it IDES. Senior leadership of VA, the services and the Joint Chiefs of Staff strongly supported this plan and the need to expand the benefits of this improved DES pilot model to all service members.

VA and DOD are now working together to launch IDES enterprise-wide. As a result, in October 2010, we started the transition from the existing legacy process to IDES using the pilot model process. Currently, there are 77 IDES sites operational nationwide, which includes the original 27, covering 72 percent of the DES population. When fully implemented in October 2011, there will be a total of 139 sites.

Through the implementation of IDES, the departments hope to create a more transparent, consistent and expedient disability evaluation process. We believe that through the implementation of the DES pilot, we have largely achieved that goal. To explain, in contrast to the DES legacy process, the pilot model provides a single disability examination and a single source disability rating that are used by both departments in executing their respective responsibility.

This results in more consistent evaluations, faster decisions and timely benefit delivery for those medically retired or separated. As a result, VA benefits can be delivered in the shortest period allowed by law following discharge, thus eliminating the pay gap that previously existed under the legacy process.

The DOD/VA integrated approach has also eliminated much of the sequential and duplicative processes found in the legacy system. Overall processing time for the delivery of DOD disability benefits will be reduced from an average of 540 days to a goal of 295 days while simultaneously shortening the period until the delivery of VA disability benefits after separation from an average of 166 days to approximately 30 days.

Through the challenges and lessons learned, DOD recognized that we expanded outside the NCR, we did not have a robust business processes in place to certify each site's preparedness before it became operational. Through analysis of lessons learned and by working with Congress, we have developed initial operating capability readiness criteria that stress quality over expedience to ensure that future sites are operationally ready for IDES.

Mr. Chairman, I will cut short the rest of my statement in the interest of time and thank you again for your support of our wounded, ill and injured service members, veterans and their families, and the opportunity to appear before you today.

[The prepared statement of Mr. Medve follows:]

STATEMENT OF

JOHN P. MEDVE

EXECUTIVE DIRECTOR OF VA/DOD COLLABORATION SERVICE

OFFICE OF POLICY AND PLANNING

U.S. DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUB-COMMITTEE ON NATIONAL SECURITY, HOMELAND DEFENSE AND FOREIGN OPERATIONS

May 4, 2011

Chairman Chaffetz, Ranking Member Tierney, and Members of the Subcommittee, good morning and thank you for the opportunity to testify before you today. My name is John Medve, Executive Director of the Department of Veterans Affairs (VA)/Department of Defense (DoD) Collaboration Service for VA's Office of Policy and Planning. I am pleased to be joined by Acting Principal Deputy Under Secretary (Personnel and Readiness) Simpson from DoD and provide the Subcommittee with an overview of collaboration between VA and DoD to ensure a seamless transition of our wounded, ill, and injured Service members from Active Duty to Veteran status. Much has been accomplished in the wake of the problems identified at the Walter Reed Army Medical Center in 2007 to improve the DoD disability process. The focus of my testimony is VA and DoD's joint efforts to make improvements and to create an integrated disability process for Service members who are being medically separated. Currently we are in the process of implementing the Integrated Disability Evaluation System (IDES); the

process used to transition the wounded, ill, and injured who are unfit for continued service, from Service member to Veteran. I will also provide information on other key VA programs that support and assist Service members throughout the transition process.

In early 2007, VA partnered with DoD to make changes to the DoD's existing Disability Evaluation System (DES). A modified process called the VA/DoD DES Pilot Model was launched in November 2007, and was intended to simplify and increase the transparency of the DES process for the Service member while reducing the processing time and improving the consistency of ratings for those who are ultimately medically separated. Authorization for the pilot was included in the National Defense Authorization Act (NDAA) 2008 and further energized our efforts for improving DoD's DES. From the outset, the Departments recognized that the VA/DoD DES Pilot Model was preceded by a maligned DoD legacy process that was, in some cases, cumbersome and redundant. The DES Pilot Model was launched originally as a joint VA/DoD process at three operational sites in the National Capital Region (NCR) and was recognized as a significant improvement over the legacy process. As a result and to extend the benefits of the Pilot Model to more Service members, VA and DoD expanded the Pilot. The Pilot Model started in the fall of 2007 with the original 3 pilot sites in the NCR and ended in March 2010, covering 27 sites and 47 percent of the DES population. In July 2010, the co-chairs of the Senior Oversight Committee (SOC) agreed to expand the pilot and rename it IDES. Senior leadership of VA, the Services, and the Joint Chiefs of Staff strongly supported this plan and the need to expand the benefits of this improved DES Pilot Model to all Service members. VA and DoD are

now working together to launch IDES enterprise-wide. As a result, in October, 2010 we started the transition from the existing legacy DES to IDES using the DES Pilot Model process. Currently there are 77 IDES sites operational nationwide (which includes the original 27 Pilot Model sites) and when fully implemented in October 2011 there will be a total of 139 sites. Through the implementation of IDES, the Departments hope to create a more transparent, consistent, and expeditious disability evaluation process for Service members being medically retired or separated and provide a more effective transition for Service members as they move from DoD to VA. We believe that through the implementation of the DES Pilot Model we have largely achieved that goal. There were challenges and lessons learned, but VA worked with its DoD partners. To explain, in contrast to the DES legacy process, the Pilot Model provides a single disability examination and a single-source disability rating that are used by both Departments in executing their respective responsibilities. This results in more consistent evaluations, faster decisions, and timely benefits delivery for those medically retired or separated. As a result, VA benefits can be delivered in the shortest period allowed by law following discharge thus eliminating the "pay gap" that previously existed under the legacy process, i.e., the lag time between a Service member separating from DoD due to disability and receiving his or her first VA disability payment.

The DoD/VA integrated approach has also eliminated much of the sequential and duplicative processes found in the legacy system. Overall processing time for the delivery of DoD disability benefits was reduced from an average of 540 days to 295 days, while simultaneously shortening the period until the delivery of VA disability benefits after separation from an average of 166 days to approximately 30 days (the

shortest period allowed by law).

Despite the overall reduction in combined processing time achieved to date, there remains room for significant improvement in IDES execution. VA and DoD recognized that as we expanded outside of the NCR, we did not have robust business processes in place to certify each site's preparedness before it became operational. Through these efforts, and our analysis of lessons learned, we have developed Initial Operating Capability (IOC) readiness criteria that stress quality over expedience to ensure that future sites are operationally ready for IDES. For a site to be deemed ready it must: (1) be able to provide exam coverage through either the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA) contracted services, or DoD; (2) have sufficient space and equipment for VA and DoD personnel; (3) meet VA information technology requirements; and (4) have local staff who have completed IDES training. If any of these criteria are not met, then IDES cannot operate at that proposed site.

In preparing for the implementation of IDES VA and DoD have hosted three joint training/planning conferences to date that set the stage for the roll-out of IDES sites. The conferences have resulted in improved communications between VA and DoD at each site, individual site assessment analyses and evaluations, and development of joint local plans to meet IOC requirements.

As the Departments continue to move forward, we are aware of the concerns and recommendations of the Government Accountability Office (GAO) in its December 2010 report entitled "Military and Veterans Disability System: Pilot has Achieved Some Goals but Further Planning and Monitoring Needed." VA agreed with the GAO

recommendations and has developed processes to improve IDES performance.

VA and DoD are committed to supporting our Nation's wounded, ill, and injured warriors and Veterans through an improved IDES. As such, VA believes that its continued partnership with DoD is critical and is nothing less than our Service members and Veterans deserve.

In addition to IDES there are several other programs VA would like to highlight that contribute to our goal of seamless transition. These programs include case management initiatives, online resources, and transition education.

TRANSITION PROGRAMS

Federal Recovery Coordination Program

The SOC established the Federal Recovery Coordination Program (FRCP) in October 2007, as a joint VA and DoD program designed to coordinate access to Federal, state, and local programs, benefits, and services for severely wounded, ill, and injured Service members, Veterans, and their families. The SOC maintains oversight of the FRCP. The program was specifically charged with providing seamless support from the time a Service member arrived at the initial Medical Treatment Facility (MTF) in the United States through the duration of care and rehabilitation. Services are now provided through recovery, rehabilitation, and reintegration into the community. Federal Recovery Coordinators (FRCs) are Masters-level prepared nurses and clinical social workers who provide for all aspects of care coordination, both clinical and non-clinical. FRCs are located at both VA and DoD facilities.

FRCs work together with other programs that serve the wounded, ill, and injured population including both clinical case managers and non-clinical care coordinators.

FRCs are unique in that they provide their clients a single point of contact regardless of where they are located, where they receive their care, and whether they remain on Active Duty or transition to Veteran status.

FRCs assist clients in the development of a Federal Individual Recovery Plan (FIRP) and ensure that resources are available, as appropriate, to assist clients in achieving stated goals. More than 1,300 clients have participated in the FRCP since its inception. Currently, the FRCP has more than 700 active clients in various stages of recovery. There are currently 22 FRCs with an average caseload of 33 clients. A satisfaction survey conducted in 2010, reported that 80 percent of FRCP clients were satisfied or very satisfied with the program.

National Resource Directory

Also established by the SOC, the National Resource Directory (NRD) is a comprehensive, Web-based portal that provides Wounded Warriors, Service members, Veterans, and their families with access to thousands of resources to support recovery, rehabilitation, and reintegration. NRD is a collaborative effort between the U.S. Departments of Defense, Labor, and Veterans Affairs and has more than 13,000 Federal, state and local resources which are searchable by topic or location. NRD's success has resulted in more than 3,000 visitors per day to the Web site. NRD is continuously improving and implementing enhancements to the Web site that were identified during recent usability testing. In April 2011, the NRD launched a mobile version of the site.

Benefits Delivery at Discharge (BDD) and Quick Start

The BDD and Quick Start programs are elements of the Veterans Benefits Administration's (VBA) strategy to provide transitional assistance to separating or retiring Service members and engage Service members in the claims process prior to discharge. VBA's goal is to ensure that every Service member separating or retiring from Active Duty who wishes to file a claim with VA for service-connected disability benefits will receive timely and effective assistance.

Participation in the BDD program is open to Service members who are within 60 to 180 days of being released from Active Duty and who are able to report for a VA examination prior to discharge. BDD's single cooperative examination process meets the requirements of a military separation examination and a VA disability rating examination. There are currently 96 BDD memoranda of understanding (MOUs) between VA and the Services covering 131 military installations throughout the Continental United States, Germany, Italy, Portugal, Azores, and Korea. The MOUs facilitate the collaboration between local VA Regional Offices (VARO) and local military installations. The BDD program goal is to provide disability compensation benefits within 60 days of discharge or retirement from Active Duty. The national average for processing is 92.3 days.

VA introduced the "Quick Start" pre-discharge claims process in July 2008. This provides Service members within 59 days of separation, or Service members within 60-180 days of separation who are unable to complete all required examinations prior to leaving the point of separation, with dedicated and expedited assistance in filing their disability claim. Since 2010, the VAROs in San Diego and Winston-Salem process all

Quick Start claims. In FY 2010, there were 54,733 claims received at MOU sites. VA and DoD are collaborating to improve the marketing and awareness strategies to increase participation in both programs.

Transition Assistance Program

The Transition Assistance Program (TAP) is conducted under the auspices of a MOU between the Departments of Labor, Defense, Homeland Security, and VA. The Departments work together scheduling briefings and classes on installations to best serve the Service members. The Departments meet quarterly to discuss marketing and improving TAP. VA's Military Service Coordinators (MSC) lead regularly scheduled TAP briefings at military installations throughout the country and at overseas locations. VA has streamlined and updated the VA portion of TAP, and in July 2011, an updated online version of the presentation will be available via eBenefits, the VA and DoD benefits information portal. In addition, VBA provides benefits transition briefings to Service members retiring, separating, and residing overseas, as well as demobilizing Reserve and National Guard members (most demobilization briefings are conducted by VHA). In FY 2010, approximately 207,000 Active Duty, Reserve, and National Guard Service members participated in over 5,000 transition briefings. For the period October 1, 2010 through March 2011, over 83,000 Active Duty, Reserve, and National Guard Service members participated in over 2,000 transition briefings.

Disabled Transition Assistance Program

The Disabled Transition Assistance Program (DTAP) provides Service members with information about VA's Vocational Rehabilitation and Employment (VR&E) program. DTAP briefings provide additional information to Service members and

Veterans who have or think they may have a service-connected disability or injury or illness that was aggravated by service. During FY 2010, over 37,000 Service members participated in 1,748 DTAP briefings around the world. Over 19,000 Service members participated in 874 DTAP briefings during the period October 1, 2010 through April 22, 2011.

eBenefits

The eBenefits online web-portal is a joint VA and DoD service that was launched in May, 2010 to provide resources and self-service capabilities to Service members and Veterans with a single sign-on. eBenefits is evolving as a "one-stop shop" for benefits applications and information, and access to personal information. VA and DoD collaborate in quarterly releases to provide users with new self-service features. Service members and Veterans can access official military personnel documents and generate civil service preference letters using the portal. Additional features allow users to apply for benefits, view the status of their disability compensation claims, update direct deposit information for certain benefits, and obtain a VA guaranteed home loan Certificate of Eligibility.

In June 2011, VA will enhance eBenefits to allow Service members to participate in TAP online. As of March 31, 2011, there were over 278,000 registered eBenefits users. Between July 1, 2010, and March 31, 2011, there were over 2 million unique visits to the eBenefits portal.

In addition to the Transition Programs just described, VA has several Transition Assistance activities designed to assist Service members during transition.

TRANSITION ASSISTANCE

VA Liaisons for Health Care

VA has a robust system in place to transition severely ill and injured Service members from DoD to VA's system of care. Typically, a severely injured Service member returns from theater and is sent to a military treatment facility (MTF) where he or she is medically stabilized. A key component of transitioning these injured and ill Service members and Veterans are the VA Liaisons for health care, who are either social workers or nurses. These VA Liaisons are strategically placed in MTFs with concentrations of recovering Service members returning from Iraq and Afghanistan. After initially having started with one VA Liaison at two MTFs, VA now has 33 VA Liaisons for health care stationed at eighteen MTFs to transition ill and injured Service members from DoD to VA's system of care. VA Liaisons facilitate the transfer of Service members and Veterans from the MTF to the VA health care facility closest to their home or the most appropriate facility that specializes in services their medical condition requires.

VA Liaisons are co-located with DoD Case Managers at MTFs and provide onsite consultation and collaboration regarding VA resources and treatment options. They also educate Service members and their families about VA's system of care, coordinate the Service member's initial registration with VA, and secure outpatient appointments or inpatient transfer to a VA health care facility as appropriate. VA Liaisons make early connections with Service members and families to begin building a positive relationship

with the VA. VA Liaisons coordinated 7,150 referrals for health care and provided over 26,825 professional consultations in fiscal year 2010.

Military Service Coordinators (MSCs)

MSCs and VBA liaisons are located at key MTFs and VA medical facilities to meet with injured Service member deployed to Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) when medically appropriate. MSCs educate Service members regarding VA benefits and services as well as additional benefits such as Social Security. MSCs assist Service members and Veterans in completing benefits claims and gathering supporting evidence to facilitate expedited processing. VBA has approximately 120 MSCs and/or liaisons providing benefits information and assistance at approximately 250 military installations.

VBA OEF/OIF/OND Coordinators

VBA places a high priority on ensuring the timely delivery of benefits to Service members and Veterans seriously injured in OEF/OIF/OND. Each VARO has a dedicated OEF/OIF/OND case manager who is responsible for overseeing the OEF/OIF/OND workload and outreach initiatives. Case managers' responsibilities include working closely with National Guard and Reserve units to obtain medical records and coordinating expedited medical examinations.

These case managers work with MTFs to ensure timely VA notification of new OEF/OIF/OND casualty arrivals and scheduling inpatient visits by VA representatives. Procedures are coordinated at the local level between VARO and MTF staff.

VARO employees contact Service members as quickly as possible to provide claims assistance and complete information on all VA benefits. Some benefits such as

home and automobile adaptation grants may be used prior to a Service members' release from Active Duty.

VHA OEF/OIF/OND Care Management

As Service members recover from their injuries and reintegrate into the community, VA works closely with VA Liaisons, FRCs, and DoD case managers and treatment teams to ensure the continuity of care. Each VA Medical Center has an OEF/OIF/OND Care Management team in place to coordinate patient care activities and ensure that Service members and Veterans are receiving patient-centered, integrated care and benefits. Members of the Medical Center's OEF/OIF/OND Care Management team include: a Program Manager, Clinical Case Managers, and a Transition Patient Advocate (TPA). The Program Manager, who is either a nurse or social worker, has overall administrative and clinical responsibility for the team and ensures that all OEF/OIF/OND Veterans are screened for case management. The severely injured are provided with a case manager and others may be assigned a case manager as indicated by a positive screening assessment or upon request. Clinical Case Managers, who are either nurses or social workers, coordinate patient care activities and ensure that all clinicians providing care to the patient are doing so in a cohesive and integrated manner. The TPA helps the Veteran and family navigate the VA system by acting as a communicator, facilitator, and problem solver. VA case managers maintain regular contact with Veterans and their families to provide support and assistance to address any health care and psychosocial needs that arise. The OEF/OIF/OND Care Management program now serves over 54,000 Service members and Veterans including over 6,300 severely injured. The current caseload each case

manager is managing on a regular basis is 54. In addition, they provide lifetime case management for another 70 Veterans by maintaining contact once or twice per year to assess their condition and needs. This is a practical caseload ratio based on the acuity and population at each VA health care facility.

VA developed and implemented the Care Management Tracking and Reporting Application (CMTRA), a Web-based application designed to track all OEF/OIF/OND Service members and Veterans receiving care management. This robust tracking system allows case managers to specify a case management plan for each individual Veteran and to coordinate with specialty case managers such as Polytrauma Case Managers, Spinal Cord Injury Case Managers, and others. CMTRA management reports are critical in monitoring the quality of care management activities throughout VHA.

OEF/OIF/OND Care Management team members are actively supporting outreach events in the community including annual Welcome Home events which are held in the community and serve as outreach to Veterans and extended family members. OEF/OIF/OND team members also participate in demobilization, Yellow Ribbon Reintegration, Post Deployment Health Reassessment events, and Individual Ready Reserve annual screening musters held to update personal information and enhance readiness. OEF/OIF/OND staff is actively making presentations to community partners, Veterans Service Organizations, colleges, employment agencies, and others to collaborate in providing services and connecting with returning Service members and Veterans.

CONCLUSION

VA remains fully committed to meeting the needs of our Nation's heroes and their families. VA and DoD continue to work together diligently to resolve transition issues while aggressively implementing improvements and expanding existing programs. These efforts continue to enhance the effectiveness of support for Wounded Warriors and their families. While we are pleased with the quality of effort and progress made to date with our joint collaboration, we fully understand our two Departments have a responsibility to continue these efforts. Through IDES, our goal was to create a less complex process, which was more transparent to the Service member, and eliminated the "pay gap" for the delivery of VA benefits. Our case management programs are designed to provide seamless support through the duration of care and rehabilitation and are constantly being improved. We continue to explore ways to expand the availability and comprehensiveness of online resources and transition education to provide Service members and Veterans direct access to the information and benefits they need.

Thank you again for your support to our wounded, ill, and injured Service members, Veterans, and their families and the opportunity to appear before you today Chairman Chaffetz, Ranking Member Tierney, this concludes my testimony. I will be happy to respond to any questions that you or other Members of the Subcommittee may have.

Mr. CHAFFETZ. Thank you.

It is my understanding that Mr. Bertoni is going to make the opening statement for the GAO. You are recognized for 5 minutes.

STATEMENT OF DANIEL BERTONI

Mr. BERTONI. Mr. Chairman, Ranking Member Cummings, members of the subcommittee, good morning.

I am pleased to discuss the Departments of Defense and Veterans Affairs' efforts to integrate their disability evaluation systems. I am joined today by Randy Williamson of our health care team, who can address any questions you may have regarding VA's Federal recovery coordination program, and Mark Bird, of our information technology team, who can field any questions on systems integration and data sharing between the departments.

Mr. Chairman, thousands of service members have been wounded or injured in Iraq and Afghanistan, and many who can't continue their military service must navigate complex disability evaluation systems in both DOD and VA. GAO and others have identified problems with these systems, including delayed decisions, duplicative processes and confusion among service members.

In 2007, DOD and VA piloted an Integrated Disability Evaluation System [IDES], to streamline and expedite the delivery of VA benefits to service members. My statement today summarizes and updates key findings of our December 2010 report, which examined the agencies' evaluation of pilot results, key implementation challenges and efforts to mitigate those challenges in advance of a planned worldwide roll-out.

In summary, in their evaluation the departments noted that the pilot had improved service member satisfaction relative to the legacy system. It met their goal for delivering VA benefits to active duty and reserve members within 295 and 305 days, respectively. Despite meeting the overall timeliness goal, not all service branches achieved the same results. Only the Army, with about 60 percent of all cases, met the established goals, while average processing times for the other services were substantially higher.

Moreover, as caseloads have increased, processing times have also steadily worsened. And as of March 2010, active duty cases took an average of 394 days to complete.

The departments have also had difficulty meeting their goal for their percentage of cases processed on time, and have since adjusted that goal downward from 80 percent to 50 percent. Over the past 6 months, the data shows that this new, lower goal has never been met for active duty cases, and only rarely for reserve and National Guard cases.

DOD and VA encountered several implementation challenges with the pilot that contributed to delays. Nearly all the sites we visited experienced staffing shortages to some degree, often due to workloads exceeding original projections. Shortages and delays were most severe at sites that had large caseload surges related to deployments. At one location, it took over 140 days to complete a single medical exam, well in excess of the 45 day goal.

We identified other issues and delays associated with this single exam, such as problems with completeness and clarity of exam summaries and disagreements between DOD and VA medical staff

on some diagnoses. Pilot sites also experienced logistical challenges such as incorporating VA staff into military facilities and housing service members awaiting a decision.

As DOD and VA proceed with rapid expansion worldwide, they are taking steps to address several challenges. This includes increasing exam and case management personnel, VA additional hiring, staff relocations and contracting, requiring more thorough assessments of site readiness and contingency plans for addressing caseload surges, and making changes to improve the quality of exam summaries.

While these initiatives are promising, we have recommended that DOD and VA take steps to ensure sites have enough military physicians to handle projected workloads, as well as available housing and operational capacity to absorb service members. It is also critical that the departments proactively assess and mitigate delays associated with diagnostic differences and insufficient exam summaries, and going forward, develop a robust data collection and monitoring mechanism to identify and address local level challenges, such as sudden staffing shortages.

In conclusion, the IDES shows promise for expediting the delivery of VA benefits to service members. However, we have identified significant challenges that require our careful attention. Although steps taken to date may mitigate these challenges, the current deployment schedule remains ambitious, in light of substantial unresolved issues and evidence of steadily worsening processing times. Thus it is unclear whether actions taken will sufficiently and timely support worldwide implementation.

Time frames aside, the ultimate success or failure of IDES will depend on DOD's and VA's ability to quickly and effectively address resource needs, make adjustments and resolve challenges as they arise, not only at initiation, but on an ongoing basis.

Mr. Chairman, this concludes my statement. I am happy to answer any questions that you or other members of the subcommittee may have. Thank you.

[The prepared statement of Mr. Bertoni follows:]

United States Government Accountability Office

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Testimony

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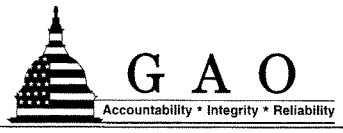
MILITARY AND VETERANS DISABILITY SYSTEM

Worldwide Deployment of Integrated System Warrants Careful Monitoring

Statement of Daniel Bertoni, Director
Education, Workforce, and Income Security Issues



GAO-11-633T

Chairman Chaffetz, Ranking Member Tierney, and Members of the Subcommittee:

I am pleased to be here today to comment on the efforts by the Departments of Defense (DOD) and Veterans Affairs (VA) to integrate their disability evaluation systems. Wounded warriors unable to continue their military service must navigate DOD's and VA's disability evaluation systems to be assessed for eligibility for disability compensation from the two agencies. GAO and others have found problems with these systems, including long delays, duplication in DOD and VA processes, confusion among servicemembers, and distrust of systems regarded as adversarial by servicemembers and veterans. To address these problems, DOD and VA have designed an integrated disability evaluation system (IDES), with the goal of expediting the delivery of VA benefits to servicemembers. After pilot testing the IDES at an increasing number of military treatment facilities (MTF)—from 3 to 27 sites—DOD and VA are in the process of deploying it worldwide. As of March 2011, the IDES has been deployed at 73 MTFs—representing about 66 percent of all military disability evaluation cases—and worldwide deployment is scheduled for completion in September 2011.

My testimony summarizes and updates our December 2010 report on the IDES[1] and addresses the following points: (1) the results of DOD and VA's evaluation of their pilot of the IDES, including updated data as of March 2011 from IDES monthly reports, where possible; (2) challenges in implementing the piloted system to date; and (3) DOD and VA's plans to expand the piloted system and whether those plans adequately address potential challenges. A detailed explanation of our methodology supporting our prior work (conducted between November 2009 and December 2010) can be found in our December 2010 report. We updated this performance audit from April to May 2011, in accordance with generally accepted government auditing standards.

In summary, DOD and VA concluded that, based on their evaluation of the pilot as of February 2010, the pilot had (1) improved servicemember satisfaction relative to the existing "legacy" system and (2) met their

[1]GAO, *Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed*, GAO-11-69 (Washington, D.C.: Dec. 6, 2010). See also GAO, *Military and Veterans Disability System: Preliminary Observations on Evaluation and Planned Expansion of DOD/VA Pilot*, GAO-11-191T (Washington, D.C.: Nov. 18, 2010).

established goal of delivering VA benefits to active duty and reserve component servicemembers within 295 and 305 days, respectively, on average. However, 1 year after this evaluation, average case processing times have increased significantly, such that active component servicemembers' cases completed in March 2011 took an average of 394 days to complete—99 days more than the 295-day goal. In our prior work, we identified several implementation challenges that had already contributed to delays in the process. The most significant challenge was insufficient staffing by DOD and VA. Staffing shortages and process delays were particularly severe at two pilot sites we visited where the agencies did not anticipate caseload surges. The single exam posed other challenges that contributed to delays, such as disagreements between DOD and VA medical staff about diagnoses for servicemembers' medical conditions that often required further attention, adding time to the process. Pilot sites also experienced logistical challenges, such as incorporating VA staff at military facilities and housing and managing personnel going through the process. DOD and VA were taking or planning to take steps to address a number of these challenges. For example, to address staffing shortages, VA is developing a contract for additional medical examiners, and DOD and VA are requiring local staff to develop written contingency plans for handling caseload surges. Given increased processing times, the efficacy of these efforts at this time is unclear. We recommended additional steps the agencies could take to address known challenges—such as establishing a comprehensive monitoring plan for identifying problems as they occur in order to take remedial actions as early as possible—with which DOD and VA generally concurred.

Background

Under the existing, or "legacy" system, the military's disability evaluation process begins at a military treatment facility when a physician identifies a condition that may interfere with a servicemember's ability to perform his or her duties. On the basis of medical examinations and the servicemember's medical records, a medical evaluation board (MEB) identifies and documents any conditions that may limit a servicemember's ability to serve in the military. The servicemember's case is then evaluated by a physical evaluation board (PEB) to make a determination of fitness or unfitness for duty. If the servicemember is found to be unfit due to medical conditions incurred in the line of duty, the PEB assigns the servicemember a combined percentage rating for those unfit conditions, and the servicemember is discharged. Depending on the overall disability rating and number of years of active duty or equivalent service, the servicemember found unfit with compensable conditions is entitled to

either monthly disability retirement benefits or lump sum disability severance pay.

In addition to receiving disability benefits from DOD, veterans with service-connected disabilities may receive compensation from VA for lost earnings capacity. VA's disability compensation claims process starts when a veteran submits a claim listing the medical conditions that he or she believes are service-connected. In contrast to DOD's disability evaluation system, which evaluates only medical conditions affecting servicemembers' fitness for duty, VA evaluates all medical conditions claimed by the veteran, whether or not they were previously evaluated in DOD's disability evaluation process. For each claimed condition, VA must determine if there is credible evidence to support the veteran's contention of a service connection. Such evidence may include the veteran's military service records and treatment records from VA medical facilities and private medical service providers. Also, if necessary for reaching a decision on a claim, VA arranges for the veteran to receive a medical examination. Medical examiners are clinicians (including physicians, nurse practitioners, or physician assistants) certified to perform the exams under VA's Compensation and Pension program. Once a claim has all of the necessary evidence, a VA rating specialist determines whether the claimant is eligible for benefits. If so, the rating specialist assigns a percentage rating. If VA finds that a veteran has one or more service-connected disabilities with a combined rating of at least 10 percent, the agency will pay monthly compensation.

In November 2007, DOD and VA began piloting the IDES. The IDES merges DOD and VA processes, so that servicemembers begin their VA disability claim while they undergo their DOD disability evaluation, rather than sequentially, making it possible for them to receive VA disability benefits shortly after leaving military service. Specifically, the IDES:

- Merges DOD and VA's separate exam processes into a single exam process conducted to VA standards. This single exam (which may involve more than one medical examination, for example, by different specialists), in conjunction with the servicemembers' medical records, is used by military service PEBs to make a determination of servicemembers' fitness for continued military service, and by VA as evidence of service-connected disabilities. The exam may be performed by medical staff working for VA, DOD, or a private provider contracted with either agency.
- Consolidates DOD and VA's separate rating phases into one VA rating phase. If the PEB has determined that a servicemember is unfit for duty,

VA rating specialists prepare two ratings—one for the conditions that DOD determined made a servicemember unfit for duty, which DOD uses to provide military disability benefits, and the other for all service-connected disabilities, which VA uses to determine VA disability benefits.

- Provides VA case managers to perform outreach and nonclinical case management and explain VA results and processes to servicemembers.

Pilot Evaluation Results Were Promising, but Degree of Improvement was Unknown, and Timeliness Has Since Worsened

In August 2010, DOD and VA officials issued an interim report to Congress summarizing the results of their evaluation of the IDES pilot as of early 2010 and indicating overall positive results. In that report, the agencies concluded that, as of February 2010, servicemembers who went through the IDES pilot were more satisfied than those who went through the legacy system, and that the IDES process met the agencies' goals of delivering VA benefits to active duty servicemembers within 295 days and to reserve component servicemembers within 305 days. Furthermore, they concluded that the IDES pilot has achieved a faster processing time than the legacy system, which they estimated to be 540 days.

Although DOD and VA's evaluation results indicated promise for the IDES, the extent to which they represented an improvement over the legacy system could not be known because of limitations in the legacy data. DOD and VA's estimate of 540 days for the legacy system was based on a small, nonrepresentative sample of cases. Officials planned to use a broader sample of legacy cases to compare against pilot cases with respect to processing times and appeal rates; however inconsistencies in how military services tracked information and missing VA information (i.e., on the date VA benefits were delivered) for legacy cases, precluded such comparisons.

While our review of DOD and VA's data and reports generally confirmed DOD and VA's findings as of early 2010, we found that not all of the service branches were achieving the same results, case processing times increased between February and August 2010, and other agency goals are not being met. Since our December report, processing times have worsened further and the agencies have adjusted some goals downward.

- *Servicemember satisfaction:* Our reviews of the survey data as of early 2010[2] indicated that, on average, servicemembers in the IDES pilot had

[2]We reviewed the agencies' survey methodology and generally found their survey design and conclusions to be sound.

higher satisfaction levels than those who went through the legacy process. However, Air Force members—who represented a small proportion (7 percent) of pilot cases—were less satisfied. Currently, DOD and VA have an 80-percent IDES satisfaction goal, which has not been met. For example, 67 percent of servicemembers surveyed in March 2011 were satisfied with the IDES. Satisfaction by service ranged from 54 percent for the Marine Corps to 72 percent for the Army.[3]

- *Average case processing times:* Although the agencies were generally meeting their 295-day and 305-day timeliness goals through February 2010, the average case processing time for active duty servicemembers increased from 274 to 296 days between February and August 2010.[4] Among the military service branches, only the Army was meeting the agencies' timeliness goals as of August, while average processing times for each of the other services exceeded 330 days. Since August 2010, timeliness has worsened significantly. For example, active component cases completed in March 2011 took an average of 394 days—99 days over the 295-day target. By service, averages ranged from 367 days for the Army to 455 days for the Marine Corps. Meanwhile, Reserve cases took an average of 383 days, 78 days more than the 305-day target, while Guard cases took an average of 354 days, 49 days more than the target.[5]

- *Goals to process 80 percent of cases in targeted time frames:* DOD and VA had indicated in their planning documents that they had goals to deliver VA benefits to 80 percent of servicemembers within the 295-day (active component) and 305-day (reserve component) targets. For both active and reserve component cases at the time of our review, about 60

[3]IDES monthly reports present participant satisfaction percentages as averages of three surveys during the IDES – MEB phase, PEB phase, and Transition phase (completion of PEB phase through discharge from service). Previous reports, which were weekly, provided separate data for each phase. Thus, we were unable to determine the extent to which satisfaction has improved or declined.

[4]We reviewed the reliability of the case data upon which the agencies based their analyses and generally found these data to be sufficiently reliable for purposes of these analyses. Our data reliability assessment included interviews regarding internal controls, electronic testing, and a trace-to-file process, where we matched a small number of randomly sampled case file dates against the dates that had been entered into the Veterans Tracking Application, the case tracking system for the IDES. For the trace-to-file process, the overall accuracy rate was 84 percent, and all but one date was 70 percent accurate or better and deemed sufficiently reliable for reporting purposes.

[5]The IDES monthly report now separates "Guard" (Army and Air Force Guard) cases from other reserve component cases for the purpose of reporting case processing times and do not provide an overall reserve component average processing time.

percent were meeting the targeted time frames. DOD and VA have since lowered their goals for cases completed on time, from 80 percent to 50 percent. Based on monthly data for 6 months through March 2011, the new, lower goal was not met during any month for active component cases. For completed Reserve cases, the lower goal was met during one of the 6 months and for Guard cases, it was met in 2 months. The strongest performance was in October 2010 when 63 percent of Reserve cases were processed within the 305-day target.

Pilot Sites Experienced Several Challenges

Based on our prior work, we found that–as DOD and VA tested the IDES at different facilities and added cases to the pilot–they encountered several challenges that led to delays in certain phases of the process.

- *Staffing:* Most significantly, most of the sites we visited reported experiencing staffing shortages and related delays to some extent, in part due to workloads exceeding the agencies' initial estimates. The IDES involves several different types of staff across several different DOD and VA offices, some of which have specific caseload ratios set by the agencies, and we learned about insufficient staff in many key positions.[6] With regard to VA positions, officials cited shortages in examiners for the single exam, rating staff, and case managers. With regard to DOD positions, officials cited shortages of physicians who serve on the MEBs, PEB adjudicators, and DOD case managers. In addition to shortages cited at pilot sites, DOD data indicated that 19 of the 27 pilot sites did not meet DOD's caseload target of 30 cases per manager.[7] Local DOD and VA officials attributed staffing shortages to higher than anticipated caseloads and difficulty finding qualified staff, particularly physicians, in rural areas. These staffing shortages contributed to delays in the IDES process.

[6]For the IDES pilot, the agencies have set targets for both DOD and VA case managers to handle no more than 30 cases at a time. However, DOD's guidance for the general disability evaluation system sets the target at a maximum of 20 cases per case manager, and agency documents related to planning for IDES expansion indicate that DOD is striving for a 1:20 caseload target for DOD case managers in the IDES. The Army has established a caseload target for MEB physicians of 120 servicemembers per physician. The Navy and Air Force have not established caseload targets for their physicians, their MEB determinations are prepared by physicians who perform other responsibilities, such as clinical treatment or supervision.

[7]Data were not available nationally to determine the extent to which sites are meeting the Army's target of 120 servicemembers per MEB physician or VA's target of 30 cases per VA case manager.

Two of the sites we visited—Fort Carson and Fort Stewart—were particularly challenged to provide staff in response to surges in caseload that occurred when Army units were preparing to deploy to combat zones. Through the Army's predeployment medical assessment process, large numbers of servicemembers were determined to be unable to deploy due to a medical condition and were referred to the IDES within a short period of time, overwhelming the staff. These two sites were unable to quickly increase staffing levels, particularly of examiners. As a result, at Fort Carson, it took 140 days on average to complete the single exam for active duty servicemembers, as of August 2010—much longer than the agencies' goal to complete the exams in 45 days. More recently, Fort Carson was still struggling to meet goals, as of March 2011. For example, about half of Fort Carson's active component cases (558 of 1033 cases) were in the MEB phase, and the average number of days spent in the MEB phase by active component cases completed in March 2011 was 197 days, compared to a goal of 35 days.

- *Exam summaries:* Issues related to the completeness and clarity of single exam summaries were an additional cause of delays in the VA rating phase of the IDES process. Officials from VA rating offices said that some exam summaries did not contain information necessary to determine a rating. As a result, VA rating office staff must ask the examiner to clarify these summaries and, in some cases, redo the exam. VA officials attributed the problems with exam summaries to several factors, including the complexity of IDES pilot cases, the volume of exams, and examiners not receiving records of servicemembers' medical history in time. The extent to which insufficient exam summaries caused delays in the IDES process is unknown because DOD and VA's case tracking system for the IDES does not track whether an exam summary has to be returned to the examiner or whether it has been resolved.

- *Medical diagnoses:* While the single exam in the IDES eliminates duplicative exams performed by DOD and VA in the legacy system, it raises the potential for there to be disagreements about diagnoses of servicemembers' conditions. For example, officials at Army pilot sites informed us about cases in which a DOD physician had treated members for mental disorders, such as major depression. However, when the members went to see the VA examiners for their single exam, the examiners diagnosed them with posttraumatic stress disorder (PTSD). Officials told us that attempting to resolve such differences added time to the process and sometimes led to disagreements between DOD's PEBs and VA's rating offices about what the rating should be for purposes of

determining DOD disability benefits. Although the Army developed guidance to help resolve diagnostic differences, other services have not.[8]

Moreover, PEB officials we spoke with noted that there is no guidance on how disagreements about servicemembers' ratings between DOD and VA should be resolved beyond the PEBs informally requesting that the VA rating office reconsider the case. While DOD and VA officials cited several potential causes for diagnostic disagreements, the number of cases with disagreements about diagnoses and the extent to which they have increased processing time are unknown because the agencies' case tracking system does not track when a case has had such disagreements.[9]

- *Logistical challenges integrating VA staff at military treatment facilities:* DOD and VA officials at some pilot sites we visited said that they experienced logistical challenges integrating VA staff at the military facilities. At a few sites, it took time for VA staff to receive common access cards needed to access the military facilities and to use the facilities' computer systems, and for VA physicians to be credentialed. DOD and VA staff also noted several difficulties using the agencies' multiple information technology (IT) systems to process cases, including redundant data entry and a lack of integration between systems.

- *Housing and other challenges posed by extended time in the military disability evaluation process:* Although many DOD and VA officials we interviewed at central offices and pilot sites felt that the IDES process expedited the delivery of VA benefits to servicemembers, several also indicated that it may increase the amount of time servicemembers are in the military's disability evaluation process. Therefore, some DOD officials noted that servicemembers must be cared for, managed, and housed for a longer period. The military services may move some servicemembers to

[8]To address such processing delays, the Army issued guidance in February 2010 stating that MEB physicians should review all of the medical records (including the results of the single exam) and determine whether to revise their diagnoses. If after doing so, the MEB physician maintains that his or her original diagnosis is accurate, he or she should write a memorandum summarizing the basis of the decision, and the PEB should accept the MEB's diagnosis.

[9]DOD and VA officials attributed disagreements about diagnoses to several factors, including the agencies identifying conditions for different purposes in the disability evaluation system, servicemembers being more willing to disclose all of their medical conditions to VA than to DOD since VA can compensate for all of the conditions, and VA examiners not receiving or not reviewing the servicemembers' medical records prior to the exam, making them unaware of the conditions for which the members had been previously diagnosed and treated

temporary medical units or to special medical units such as Warrior Transition Units in the Army or Wounded Warrior Regiments in the Marine Corps, but at a few pilot sites we visited, these units were either full or members in the IDES did not meet their admission criteria. In addition, officials at two sites said that members who are not gainfully employed by their units and left idle are more likely to be discharged due to misconduct and forfeit their disability benefits. However, DOD officials also noted that servicemembers benefit from continuing to receive their salaries and benefits while their case undergoes scrutiny by two agencies, though some also acknowledged that these additional salaries and benefits create costs for DOD.

Deployment Plans Address Many, but not All, Challenges

DOD and VA are deploying the IDES to military facilities worldwide on an ambitious timetable—expecting deployment to be completed at a total of about 140 sites by the end of fiscal year 2011. As of March 2011, the IDES was operating at 73 sites, covering about 66 percent of all military disability evaluation cases.

In preparing for IDES expansion militarywide, DOD and VA had many efforts under way to address challenges experienced at the 27 pilot sites. For example, the agencies completed a significant revision of their site assessment matrix—a checklist used by local DOD and VA officials to ascertain their readiness to begin the pilot—to address areas where prior IDES sites had experienced challenges. In addition, local senior-level DOD and VA officials will be expected to sign the site assessment matrix to certify that a site is ready for IDES implementation. This differs from the pilot phase where, according to DOD and VA officials, some sites implemented the IDES without having been fully prepared.

Through the new site assessment matrix and other initiatives, DOD and VA planned to address several of the challenges identified in the pilot phase.

- *Ensuring sufficient staff:* With regard to VA staff, VA planned to increase the number of examiners by awarding a new contract through which sites can acquire additional examiners. To increase rating staff, VA filled vacant rating specialist positions and anticipates hiring a small number of additional staff. With regard to DOD staff, Air Force and Navy officials told us they added adjudicators for their PEBs or planned to do so. Both DOD and VA indicated they plan to increase their numbers of case managers. Meanwhile, sites are being asked in the assessment matrix to provide longer and more detailed histories of their caseloads, as opposed to the

1-year history that DOD and VA had based their staffing decisions on during the pilot phase. The matrix also asks sites to anticipate any surges in caseloads and to provide a written contingency plan for dealing with them.

- *Ensuring the sufficiency of single exams:* VA has been revising its exam templates to better ensure that examiners include the information needed for a VA disability rating decision and to enable them to complete their exam reports in less time. VA is also examining whether it can add capabilities to the IDES case tracking system that would enable staff to identify where problems with exams have occurred and track the progress of their resolution.

- *Ensuring adequate logistics at IDES sites:* The site assessment matrix asks sites whether they have the logistical arrangements needed to implement the IDES. In terms of information technology, DOD and VA were developing a general memorandum of agreement intended to enable DOD and VA staff access to each other's IT systems. DOD officials also said that they are developing two new IT solutions—one intended to help military treatment facilities better manage their cases, another intended to reduce multiple data entry.

  However, in some areas, DOD and VA's efforts to prepare for IDES expansion did not fully address some challenges or are not yet complete. For these areas, we recommended additional action that the agencies could take, with which the agencies generally concurred.

- *Ensuring sufficient DOD MEB physician staffing:* DOD does not yet have strategies or plans to address potential shortages of physicians to serve on MEBs. For example, the site assessment matrix does not include a question about the sufficiency of military providers to handle expected numbers of MEB cases at the site, or ask sites to identify strategies for ensuring sufficient MEB physicians if there is a caseload surge or staff turnover. We recommended that, prior to implementing IDES at MTFs, DOD direct military services to conduct thorough assessments of the adequacy of military physician staffing for completing MEB determinations and develop contingency plans to address potential shortfalls, e.g. due to staff turnover or caseload surges.

- *Ensuring sufficient housing and organizational oversight for IDES participants:* Although the site assessment matrix asks sites whether they will have sufficient temporary housing available for servicemembers going through the IDES, the matrix requires only a yes or no response and does not ensure that sites will have conducted a thorough review of their

housing capacity. In addition, the site assessment matrix does not address plans for ensuring that IDES participants are gainfully employed or sufficiently supported by their organizational units. We recommended that prior to implementing the IDES at MTFs, DOD ensure thorough assessments are conducted on the availability of housing for servicemembers and on the capacity of organizational units to absorb servicemembers undergoing the disability evaluation; alternative housing options are identified when sites lack adequate capacity; and plans are in place for ensuring that servicemembers are appropriately and constructively engaged.

- *Addressing differences in diagnoses:* According to agency officials, DOD is currently developing guidance on how staff should address differences in diagnoses. However, since the new guidance and procedures are still being developed, we cannot determine whether they will aid in resolving discrepancies or disagreements. Significantly, DOD and VA do not have a mechanism for tracking when and where disagreements about diagnoses and ratings occur and, consequently, may not be able to determine whether the guidance sufficiently addresses the discrepancies. Therefore, we recommended that DOD and VA conduct a study to assess the prevalence and causes of such disagreements and establish a mechanism to continuously monitor diagnostic disagreements. VA has since indicated it plans to conduct such a study and make a determination by July 2011 regarding what, if any, mechanisms are needed.

  Further, despite regular reporting of data on caseloads, processing times, and servicemember satisfaction, and preparation of an annual report on challenges in the IDES, we determined that DOD and VA did not have a systemwide monitoring mechanism to help ensure that steps they took to address challenges are sufficient and to identify problems in a more timely basis. For example, they did not collect data centrally on staffing levels at each site relative to caseload. As a result, DOD and VA may be delayed in taking corrective action since it takes time to assess what types of staff are needed at a site and to hire or reassign staff. DOD and VA also lacked mechanisms or forums for systematically sharing information on challenges, as well as best practices between and among sites. For example, DOD and VA have not established a process for local sites to systematically report challenges to DOD and VA management and for lessons learned to be systematically shared systemwide. During the pilot phase, VA surveyed pilot sites on a monthly basis about challenges they faced in completing single exams. Such a practice has the potential to provide useful feedback if extended to other IDES challenges.

To identify challenges as they arise in all DOD and VA facilities and offices involved in the IDES and thereby enable early remedial action, we recommended that DOD and VA develop a systemwide monitoring mechanism. This system could include continuous collection and analysis of data on DOD and VA staffing levels, sufficiency of exam summaries, and diagnostic disagreements; monitoring of available data on caseloads and case processing time by individual VA rating office and PEB; and a formal mechanism for agency officials at local DOD and VA facilities to communicate challenges and best practices to DOD and VA headquarters. VA noted several steps it plans to take to improve its monitoring of IDES workloads, site performance and challenges—some targeted to be implemented by July 2011—which we have not reviewed.

Concluding Observations

By merging two duplicative disability evaluation systems, the IDES has shown promise for expediting the delivery of VA benefits to servicemembers leaving the military due to a disability. However, we identified significant challenges at pilot sites that require careful management attention and oversight. We noted a number of steps that DOD and VA were undertaking or planned to undertake that may mitigate these challenges. However, the agencies' deployment schedule is ambitious in light of substantial management challenges and additional evidence of deteriorating case processing times. As such, it is unclear whether these steps will be sufficiently timely or effective to support militarywide deployment. Deployment time frame notwithstanding, we continue to believe that the success or failure of the IDES will depend on DOD and VA's ability to quickly and effectively address resource needs and resolve challenges as they arise, not only at the initiation of the transition to IDES, but also on an ongoing, long-term basis. We continue to believe that DOD and VA cannot achieve this without a robust mechanism for routinely monitoring staffing and other risk factors.

Chairman Chaffetz and Ranking Member Tierney, this concludes my prepared statement. I would be pleased to respond to any questions that you or other Members of the Subcommittee may have at this time.

GAO Contact and Staff Acknowledgment

For further information about this testimony, please contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. In addition to the individual named above, key contributors to this testimony include Michele Grgich, Greg Whitney, and

Daniel Concepcion. Key advisors included Bonnie Anderson, Mark Bird, Sheila McCoy, Patricia Owens, Roger Thomas, Walter Vance, and Randall Williamson.

Related GAO Products

Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed. GAO-11-69. Washington, D.C.: December 6, 2010.

Military and Veterans Disability System: Preliminary Observations on Evaluation and Planned Expansion of DOD/VA Pilot. GAO-11-191T. Washington, D.C.: November 18, 2010.

Veterans' Disability Benefits: Further Evaluation of Ongoing Initiatives Could Help Identify Effective Approaches for Improving Claims Processing. GAO-10-213. Washington, D.C.: January 29, 2010.

Recovering Servicemembers: DOD and VA Have Jointly Developed the Majority of Required Policies but Challenges Remain. GAO-09-728. Washington, D.C.: July 8, 2009.

Recovering Servicemembers: DOD and VA Have Made Progress to Jointly Develop Required Policies but Additional Challenges Remain. GAO-09-540T. Washington, D.C.: April 29, 2009.

Military Disability System: Increased Supports for Servicemembers and Better Pilot Planning Could Improve the Disability Evaluation Process. GAO-08-1137. Washington, D.C.: September 24, 2008.

DOD and VA: Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers. GAO-08-514T. Washington, D.C.: February 27, 2008.

DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers. GAO-07-1256T Washington, D.C.: September 26, 2007.

Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members. GAO-06-362. Washington, D.C.: March 31, 2006.

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Mr. CHAFFETZ. Thank you. I appreciate that.

I am going to recognize myself for 5 minutes. Ms. Simpson, Mr. Medve, I appreciate the task that you have before you. When I hear, see and read what the GAO has to say and I listen to your statements and presentations, it seems like you are on a different planet. That is the concern.

Let me ask specifically, because I hope at the conclusion of this we have at least some sense of the timing, the realistic timing, the cost of this, I haven't heard much mention of what this is all costing, and some explanation of why it is taking so long. Because we talked about May 3, 2007, virtually about 4 years almost to the date, and yet we feel like we are still sliding backward as opposed to forward.

Can veterans now download their electronic medical records with the click of a mouse? Yes or no, Ms. Simpson?

Ms. SIMPSON. Yes, they can, both with the VA and from TriCare Health Agency.

Mr. CHAFFETZ. Mr. Medve, can they do that?

Mr. MEDVE. They can do it through the Blue Button system, Mr. Chairman. They can download information from the medical records into Blue Button.

Mr. CHAFFETZ. Can we get the assessment from the GAO? Is that something that they can do, click on the mouse and download their records?

Mr. BIRD. Yes, they can, but the information that is available to them may be limited.

Mr. CHAFFETZ. Explain that to me.

Mr. BIRD. Well, there are, not all medical records are necessarily in electronic form.

Mr. CHAFFETZ. So my understanding is that what is in electronic form is what they self-import, right? What they themselves put into the system? Or is it broader than that?

Mr. BIRD. No, it is broader.

Mr. CHAFFETZ. But is it complete?

Mr. BIRD. It may not be complete.

Mr. CHAFFETZ. How do they figure out if it is complete or not? That is one of the issues, right? The President made this quote during the State of the Union: "Veterans can now download their electronic medical records with the click of a mouse." But then right after that, we had the Iraq and Afghanistan Veterans of America president comment that was not true. And he said, "The President's comments are misleading to service members, veterans and the American public who now think that this system is in place and functional, while it is clearly not."

Is he right or is he not right? Mr. Bird.

Mr. BIRD. As I said, there is information that is readily available at the click of a button. But the information for all veterans in all cases may not be complete.

Mr. CHAFFETZ. Do you have any sense of how do we get to that finish line? How much of it is in there? What percentage of this is actually done? And how do we get to that finish line? It is a huge, mammoth task, no doubt about it.

Mr. BIRD. Yes. The Departments frankly have been working on this, the exchange, the electronic exchange of health records, for

over 10 years. They have slowly been increasing the extent to which they can exchange records, starting back in 1998, to the present time.

There are in some cases limitations in the systems within the Departments that preclude the full exchange of medical records for any individual.

Mr. CHAFFETZ. How close are they to completing this? Is it next month? Is it next year? If there is a spectrum, and we are trying to get to the finish line, and I recognize it is an ongoing process, but information technology is supposed to make life simpler, easier, swifter, more effective, more efficient, not more burdensome. Where are we on that spectrum?

Mr. BIRD. Well, it is difficult to say, because the extent of the problem hasn't necessarily been defined yet by the Departments. The desired end state is frequently moving as technology improves, and as certain capabilities are delivered, people want more.

Mr. CHAFFETZ. Would anybody else from the GAO care to comment on that?

Mr. BERTONI. I could talk more on that from a logistics and operational standpoint with the IDES. The larger macro issue of data sharing between DOD and VA affects not only, primarily folks who have left the services and are in the world and need to get their records and it is very difficult. In terms of the IDES, that is pretty much a self-contained unit. You have VA staff, you have DOD staff in these medical treatment facilities. And the problem they have is their individual systems haven't been integrated sufficiently onsite.

So we have work-arounds, we have manual processes, we have multiple computers on individuals' desks to sort of access multiple sites. But in the case of this project, would it expedite if they had a seamless access to each others' records? Yes. Would it facilitate quicker processing? Absolutely. Is it the Achilles heel for this system? No. I think there are bigger issues.

Mr. CHAFFETZ. And what are those bigger issues?

Mr. BERTONI. Initially I think not staffing these sites appropriately, not maintaining the ratios of staff to workloads, to cases. Just not having the appropriate knowledge, skills and ability on the ground when these sites were stood up. Primary.

Mr. CHAFFETZ. There is lots more to discuss, but I am coming to the conclusion of my time with respect to the 5-minutes. We will now recognize Mr. Welch from Vermont for 5 minutes.

Mr. WELCH. Thank you, Mr. Chairman. I appreciate your calling this hearing.

Mr. Williamson, I want to thank you for conducting the GAO study, which I and others had requested after that Washington Post series of articles. I missed your opening statement, so I apologize if you have to re-cover answers that you have already given. But can you please share how the findings of that study can help this committee on how we can move forward in making the transition from DOD to the VA more streamlined for our soldiers?

Mr. WILLIAMSON. The study we completed on March 23rd was on the Federal Recovery Coordination Program. And as you may know, that is a program for the most severely catastrophically injured, ill and wounded service members. In the process of that, we have obviously looked at a variety of other programs.

As you know, each of the services has their own wounded warrior program. And in addition to the Federal Recovery Coordination program, which is administered by VA, there is a recovery coordination program administered by DOD as well. So there are a lot of organizations that are involved in terms of care coordination and case management.

Some of the IT issues in terms of coordination, just to kind of follow on what the chairman was talking about, it is very important, because of the overlap that occurs between all the programs, the wounded warrior programs that are now ongoing, very important that these programs coordinate with one another. Right now, the recovery coordination program has a comprehensive transition plan and the FRP also has that.

So it is important that if they are not talking to one another, or can't communicate with one another, they have problems. We had a situation where——

Mr. WELCH. I am not going to have a lot of time. What I think would be helpful is, on the basis of your study, what are the one, two, three types of recommendations that you might have?

Mr. WILLIAMSON. The recommendations deal with proper identification of potential enrollees. Right now they need to do a better job of identifying the people who are severely wounded. And that is an issue because there is no good data base of severely wounded people.

No. 2, determining a number of staff and the workload ratio, so that we don't overload. And three, where to place the people.

Mr. WELCH. All right, thank you.

Let me ask Ms. Simpson and Mr. Medve a question. When the Vermont Guard returned, we had our largest Guard deployment since the Second World War, over 200 were kept on medical hold with the DOD and not able to return home to their family to begin that reintegration process. The question is, how can members of the National Guard and Reserve have access to the high quality care that is provided by the Department of Defense without losing the opportunity to get the benefits of receiving that care closer to home? That is particularly a challenge for our members of the Guard who are, many of them, living in very rural and remote areas. I will start with you, Ms. Simpson.

Ms. SIMPSON. Thank you, Mr. Welch. I think the issues that you highlighted for the Guard are of upmost priority to both Departments. Because of the unique nature of the Guard being part of a community, it is more difficult to get services to them.

However, that being said, there has been an increased emphasis to ensure that they not only have the benefits and care from these transition units, but also making an outreach to the community. The Army in particular has done a good job trying to reach back to the communities on behalf of the Guard and Reserve community.

There is more to be done, obviously, because that Guard and Reserve community is one of our highest priorities, as some of their statistics are not as good as some of the others. So we are working on that exact issue.

Mr. WELCH. Thank you. Mr. Medve.

Mr. MEDVE. Congressman, thank you for the question. As Ms. Simpson said, we are looking at the specific issues surrounding

Guard and Reserve. When they return from a deployment, DOD has been, as we look at somebody that may be unfit, we are working through those specific issues of getting them through the IDES program and looking for ways that we can do this treatment much closer to the home base to ensure that we have the requisite staff that can handle that influx.

Mr. WELCH. Thank you. I yield back.

Mr. CHAFFETZ. The gentleman yields back. Thank you.

We will now recognize the vice chairman, Mr. Labrador from Idaho, for 5 minutes.

Mr. LABRADOR. Thank you, Mr. Chairman.

Mr. Bird, I just want to followup on a question that the chairman asked you. I am not sure I understood your answer. In the State of the Union, President Obama stated that veterans can now download their electronic medical records with the click of a mouse. And you said that is somewhat true.

But you were not specific enough, letting us know exactly what they can download. I am just going to quote the president of the Iraq and Afghanistan Veterans of America. He said that "The comments are misleading to service members, veterans and members of the American public who now think that the system is in place and functional. This is clearly not." Then he says specifically that from the VA system what you can download are pharmaceutical records and personal health information that he or she has self-entered.

Is that an accurate statement?

Mr. BIRD. I believe that is an accurate statement.

Mr. LABRADOR. So that is all you can download right now, is pharmaceutical records and then self-input information?

Mr. BIRD. That is my understanding.

Mr. LABRADOR. So what do you think the President meant when he said that veterans can now download all this information?

Mr. BIRD. I wouldn't want to speculate.

Mr. LABRADOR. Anybody else want to take a crack at that?

OK. Ms. Simpson, could you please comment on that?

Ms. SIMPSON. I was just going to say that I think the Blue Button, as Mr. Medve mentioned, is a reference to trying to get to that goal that you are talking about, the full electronic health record, and that has made significant progress. I am not technically detailed in the exact information that the member can get, though. But the Blue Button, as Mr. Medve said, is the way that they get the information.

Mr. LABRADOR. So we are trying to achieve this compliance, where they can actually download. But it sounds like we are not really there yet.

Now, we have a system, the IDES system, and we also have the legacy DES system. Ms. Simpson, can you tell me what was the projected cost of the legacy DES program?

Ms. SIMPSON. I don't have that figure for the cost, but we can get that for you.

Mr. LABRADOR. OK. I want to know what the projected cost was, and I want to know what the actual cost was. Do you, Mr. Medve, have that information?

Mr. MEDVE. Sir, DES is a DOD program, so I wouldn't have that information on IDES in terms of our projections for health care with VHA and VA. Those are embedded in their overall budget, because frankly, service members who transition through IDES would be our customers anyway. So we project for that population.

Mr. LABRADOR. Can you provide that information for the record?

Mr. BERTONI. Sir, I actually have, as of November I have some numbers.

Mr. LABRADOR. That would be great.

Mr. BERTONI. DOD estimates $63 million annually for the IDES, with VBA's portion about $33 million and VHA at $17 million. And additional benefits paid out would be $960 million.

Mr. LABRADOR. What was the projected cost?

Mr. BERTONI. I do not know the projected, just what their estimates were at that time.

Mr. LABRADOR. Thank you.

According to your testimony, Mr. Medve, you said that through the implementation of IDES, the Departments hope to create a more transparent, consistent, expeditious program. And you believe that it will largely achieve the goal of creating a more transparent, consistent program. Why do you think that is, just largely? Do you think that it is going to achieve these goals, or do you think that it is not going to achieve the goals?

Mr. MEDVE. I believe it will achieve the goals. In many cases, we have, with service members.

Mr. LABRADOR. Does GAO agree with this assessment, Mr. Bertoni?

Mr. BERTONI. I think the concept of transparency is built into it. We have a system unlike the legacy system, where we have case management, clinical, non-clinical case management from referral through payment of VA benefits. So to the extent that these folks are able to do their job, they have sufficient workloads and ratios where they can actually speak with the service member and explain to them why things are happening the way they are, why the decisions are playing out the way they are. I think you do have a much more transparent system.

Mr. LABRADOR. Mr. Chairman, I have no more questions, just one last comment. It seems to me that we have had this problem for 4 years, trying to figure out how the system works. This is a lot of the same stuff we are going to be doing with the health care system, if it goes national. So I have some concerns about the projected costs in the future for a health care system.

Mr. CHAFFETZ. Thank you. The gentleman yields back.

I now recognize the ranking member of the committee, Mr. Tierney from Massachusetts, for 5 minutes.

Mr. TIERNEY. I thank the chairman. I thank the chairman for having this hearing, as well, as the folks on the dais for testifying.

Mr. Bertoni or Mr. Williamson, Mr. Bird, let me ask you folks one thing. Is it your impression that the Veterans Administration and the Department of Defense completed all the recommendations that you made with respect to their pilot program?

Mr. BERTONI. We have made recommendations dating back to 2007. To the extent that we have asked them to institute more robust assessment practices while they were going through the pilot,

we think they have been fairly responsive. I would say responsive. I think the design of the pilot was better, the metrics they were capturing were better because they were responsive to our recommendations.

Down the road, we just issued a report in December where we have several recommendations in which they have agreed. To the extent that they complete them, I think they will have a positive impact.

Mr. TIERNEY. Do you have an estimate of how long it should take them to complete the recommendations from December?

Mr. BERTONI. There are some estimates. We had asked them to look at the extent to which there are disagreements and diagnoses between DOD and VA, which we believe could be substantial. I have been doing this quite a while, and usually Federal disability programs, cases tend to get mired in the mud when you can't complete the medical record or you have disagreements about the medical record. They sit on desks, they have to be looked at again. Medical exams expire and we see the service member on the disability evaluation hamster wheel.

So we think they really need to look at this issue. I believe they intend to study it and make a determination of whether adjustments need to be made by July 2011. And there are other areas where they are actively right now making adjustments.

Mr. TIERNEY. To what extent, if any, do you think that this disagreement, or maybe substantial disagreements on disability, would be a case of hoping that the other department or agency incurs the cost?

Mr. BERTONI. I don't think that is the issue. I think it just, it is the way their criteria is laid out in terms of how they assess disability. Terminology, nomenclature, guidance, I think there are just fundamental differences across the two entities. And things get lost in the translation.

Right now, there is guidance being developed. We haven't seen it, and we really don't know how it is going to address this problem. What we are really concerned about is, we went to 10 sites. We heard this at enough sites to raise it to the attention of the agencies, that you really need to get your hand around extent, nature and the impact on delays. That is good information to make some adjustments.

Mr. TIERNEY. Mr. Medve and Ms. Simpson, is there any talk in the Veterans Administration or Department of Defense about kicking this up to the White House level to get a referee? Somebody has to be able to make a decision, as opposed to letting it keep being arbitrated and negotiated back and forth. At some point, somebody has to have some leadership, a sense of direction, make a decision and force movement.

Mr. MEDVE. Mr. Ranking Member, as Mr. Bertoni said, one of the recommendations was for us to look at those discrepancies. As he said, we are undergoing a study right now which will be coming out in July. We are also looking at a number of variety of ways, because as he points out, most of the cases that there is a discrepancy, it resolves around the mental health issues. Those are tough calls to make in terms of service members. So while the DOD doctors will have had a service member for a while and have an opin-

ion, and then when we do the exam, we may come to a different conclusion.

So we are working out a way that we can leverage the ongoing treatment, get that in a form where our raters can look at that, and then use that as the basis for making the determination which should help eliminate any discrepancies.

Mr. TIERNEY. Had nobody identified that issue between the time that you were working on the pilot and the time you decided to start trying to scale this program up? It sounds to me like there was no plan on how the scaling up was going to happen.

Mr. MEDVE. I can't answer that question. I wasn't there during the pilot phase of it. I know a number of these issues, we are dealing with individual cases. So as you are dealing with individual service members——

Mr. TIERNEY. I don't want to interrupt you, but my time is short. I know we are dealing with individual cases, and I am aware of all the difficulties that presents. But when we had a pilot program, presumably we identified some of the issues there. Before we went to moving to scaling it up, I would have thought there would have been a plan, and the plan would have involved resolving some of these issues.

Mr. Bertoni, are you aware of any plan where they said, these are the issues, we are going to get these resolve and this is how we are going to deal with it as we scale it up?

Mr. BERTONI. Certainly the pilot identified challenges that the DOD and VA have undertaken efforts to address. I think one of the issues was at the time they issued that report in August 2010 that there were only 1,300 completed cases. They were working off of data that was 6 months old at the time they began analyzing it.

So I think some of the emerging issues just hadn't worked their way through the system yet. By the time we started to look, a year later, at some of the data, some of these trends were starting to play themselves out more fully. So making decisions on the basis of 1,300 cases on the goodness of the pilot, they were able to do that in some respects. But I don't think they knew everything that was going to be coming down the road.

Mr. TIERNEY. Thank you.

Mr. CHAFFETZ. Thank you. We will now recognize Mr. Gosar of Arizona for 5 minutes.

Mr. GOSAR. Mr. Williamson, let me make sure I've got this right. You made a comment just a minute ago, because of lack of documentation of the injured. Are you kidding me? Is that true?

Mr. WILLIAMSON. Well, again, the Federal Recovery Coordination program covers the severely injured. And there is no data base in DOD or VA that actually defines what severely wounded is, or keeps track of it. So it makes it difficult for the program to identify potential enrollees.

Mr. GOSAR. Well, this seems just backward to me. I am a dentist, and health records are everything to a patient for continuity of care. And I see this over and over in my district. We collect claims from White Mountains to Native Americans to Flagstaff to Prescott to Phoenix all about this. And this is the simplest of tasks. And it comes back to the lack of an interagency discipline to have some-

thing that both agencies can agree upon. Would you not agree on that, Ms. Simpson and Mr. Medve?

Ms. SIMPSON. I think absolutely it requires both departments working together, throughout the entire department at the senior levels of leadership to address those specific issues. I believe that the teams are working to address those.

Mr. GOSAR. Wasn't there a meeting on May 2nd? What was the followup on that? Can you give us some details?

Ms. SIMPSON. I was not present at the meeting. We are in the process of documenting the next steps for both the issues of the electronic health record and the disability evaluation system and the way forward. Both departments will be connecting on that to get specifics in addressing those issues.

Mr. GOSAR. I find a real disconnect, I am sorry, but these are people's lives. Having gone over to Walter Reed to see the severely injured, to see even some of the folks who are looking at problems with post-traumatic syndrome type aspects, folks, it is that easy.

It seems like we are just studying this over and over and over again, going nowhere. It is a common theme throughout our whole, my district, which is laden with veterans and our military supporters. This is unacceptable. Just absolutely unacceptable. Because the whole system is now in place and it is a problem, it is interfering with the treatment of our soldiers. Would you not agree?

Ms. SIMPSON. Access to data and information absolutely is critical to being able to address issues, I agree.

Mr. GOSAR. Then why aren't we prioritizing that record? This is no different. I am not going to give you any solace. Because in the private sector, we are not given that leeway. And I don't see we should be giving you any more leeway because of what is impounding here. And not to have documentation on severely wounded people that are coming back here, that is the minimum standard, folks. That is a minimum standard. What you are giving us is unacceptable results, absolutely unacceptable results.

Not knowing what came about on May 2nd, Ms. Simpson, where would you go with this? You are in a position of making a comment and putting your weight behind an idea. Where would you like to see this go?

Ms. SIMPSON. I believe we would like to see it go to exactly what you are talking about, commitment and service to getting our service members and our wounded warriors into veteran status seamlessly. It has to be the upmost priority. And the technical aspects of the systems, I am not detailed in that type of information, but there are very dedicated people in both departments that are working tirelessly to make sure that the technical, systematic architecture and the details about the infrastructure that is required to support the record you are referring to is going to be a reality.

Mr. GOSAR. I would hope somebody in leadership would actually stand up and be counted. Because too many times our men and women who put their lives on the line are being the victims here. That is inappropriate.

We have heard this over and over again, throughout my district, like I said. I would like to say, in a few short weeks, we are going to celebrate Memorial Day. I hope, especially, it is very important

during this time, that we remember our obligations. It is not about saving our jobs, it is not about not speaking up. It is about speaking up on behalf of what is right. I don't see a lot of that happening.

Thank you, Mr. Chairman.

Mr. CHAFFETZ. Thank you. The gentleman yields back.

We will now recognize Mr. Quigley from Illinois for 5 minutes.

Mr. QUIGLEY. Thank you, Mr. Chairman.

Ms. Simpson, I will ask you but if anyone else wants to chime in, I would appreciate it. Isn't it true that the problems at Fort Carson is really a staffing problem? Are you concerned that this is not just Fort Carson, but these systemic shortages could lead to these same delays across the entire system?

Ms. SIMPSON. I think an element of the issues at Fort Carson was the staffing issue. One of the actual lessons learned from the pilot, the first pilot, was in fact having accountability and a thorough assessment of making sure that all aspects of the requirements to integrate the systems was in place before going live. So the teams now are going around to the different sites and looking at best practices. Not every site has the severity of the issues as identified in Fort Carson.

But to address that, we are looking at the other sites to incorporate the lessons learned there, and getting more specific in the metrics, they are consistent across all the sites.

Mr. QUIGLEY. Then how much of it is the staffing issue there, and what is the danger of it spreading? How do you break it down? Is it the analysis you are doing now to try to answer that question?

Mr. MEDVE. If you don't mind, Congressman, one of the things that we learned in terms of as we move forward with IDES is we had not instituted a process that brought together the teams before they stood up in their respective sites and applied a rigorous methodology of making sure they understood what they were getting into as they were going to implement.

We started that back in September with the first iteration where we brought them all together. We sat them as groups. We had them do a site assessment and then from that site assessment it went through a murder board where people looked at their analysis and after that analysis, they developed their draft implementation plan.

So they got a good sense of where they were from a requirements standpoint, in terms of what they needed for staffing. And then developed their plan and had to be certified by two senior executives, one from DOD, one from VA, for each local site. That again I think is building on the recommendations that the GAO made.

As part of that they also had to develop contingency plans, should there be an influx of how they would handle additional cases coming into the system. So I think what happened at Fort Carson, we did learn that lesson, we have embedded it and institutionalized it in our going-forward plan for rolling it out for the rest of the fiscal year.

Mr. QUIGLEY. I can't help, Mr. Chairman, my frustration here is I am flashing back to my academic days in public policy. I feel like I am getting an answer that would be suitable for a public administration class. In layman's terms, the essence of the problem, how

much of it is staffing, how much of it is we just screwed up and didn't know how to do this the right way?

Mr. MEDVE. Sir, I think at the beginning we didn't have as good a plan as we needed. We did not apply the leadership from the local level up. And we have now turned that around to where the Chief of Staff of the Department of Veterans Affairs and the Vice Chief of Staff of the Army have quarterly VTCs with the Army IDES sites to hold each site and both Department personnel accountable for that. We are examining the staffing as part of that process. And if there is a requirement to add more staff, we are doing it.

Mr. QUIGLEY. I respect how difficult this is. I really do. I guess I don't understand how it can crop up. It sounds like the first day on the job. Doing this for a long time, what changed to make it all of a sudden a problem that you had to uncover?

Mr. BERTONI. Sir, I could take a crack at that from a GAO standpoint. I think, as Mr. Medve stated, the up-front work in terms of doing a look-back on the history of Carson would have been very helpful, a more granular look, a month by month look at what the deployment schedules looked like, what did the impairments look like, numbers, types of impairments, illnesses, injuries. Then you can build your knowledge, skills and abilities around that.

In the case of Carson, there was a large shortage in specialty medical exams. Many of these folks are coming back from multiple deployments. The science says when you go through multiple deployments, more likely to have PTSD and other mental impairments to deal with.

So if you know the history of the site, you can build your staffing model around that and be ready for surges. That was not done. We think it is being done better now.

Mr. QUIGLEY. Is it possible to continue? Thank you, Mr. Chairman. Then it gets to the question, if this is new, is it because we are in uncharted territory about how many deployments we are sending our young men and women to? Anybody?

Ms. SIMPSON. The deployments piece is not new. I think the new——

Mr. QUIGLEY. The deployment what?

Ms. SIMPSON. The deployment assessments is not new.

Mr. QUIGLEY. But what is new is how many deployments we are asking our people to go on, to go through.

Ms. SIMPSON. I think what we are trying to say, or at least Mr. Medve and I are trying to say, is the issues that were not addressed in the first look at the pilot were categorized into a plan. And now they have constant interaction and talking with one another through these various forums that Mr. Medve mentioned. And the constant attention to making sure that all of the staffing, the facilities, all of the things that are required to make sure that the site is able to function at the upmost quality is there.

Mr. QUIGLEY. Mr. Chairman, I want to thank our participants. With the greatest respect, I am not any smarter—maybe that is an attack on me—after this discussion than I was coming in and reading this and being prepared. But I do appreciate what you have done to put this together.

Mr. CHAFFETZ. Thank you. The gentleman yields back.

We will now recognize the gentleman from Texas, Mr. Farenthold, for 5 minutes.

Mr. FARENTHOLD. Thank you very much.

I never cease to be amazed at the inability of the Federal Government to create what seems to me to be a relatively simple computer system that works. I am stunned by it.

I want to take a step back and just kind of look at what is actually involved in doing this. We had a comment, I think it was Mr. Medve, that we had some staffing issues. Are the staffing issues doctors? Are the staffing issues data input clerks? Where is the staffing problem? That is my first question.

Mr. MEDVE. In terms of IDES, what we needed to understand was what the requirement was at each site, based on their specific requirements. So it was a combination of ensuring that we had the amount of medical professionals who could do the examinations, that we had the requisite number of VA military service coordinators to handle the cases. And then correspondingly, the DOD had the number of physical evaluation board liaison officers.

Mr. FARENTHOLD. OK. Well, here is my concern on this. I actually have a little bit of experience in this. I had a computer company before I came to Congress. We were approached by a chain of five minor emergency centers that wanted to do an electronic medical records system, online and Web-based. We did that with five people in 4 months.

Now, I realize you have a whole lot bigger scale. But it doesn't seem like it is a whole lot different project, with maybe the addition of some workflows. You have a doctor in the military that sees them. They dictate the report, or they enter it into the computer themselves.

Then they move on, get discharged, they move on to the Veterans Administration. They get evaluated by another doctor, who dictates or enters that report. It gets reviewed by somebody that says yes or no, and the checks start coming.

I realize that is a gross oversimplification. But it seems to me that is a pretty simple data base application with some workflow. I would bet if you put it just in simple terms and gave it to a student at Harvard, he could probably get it done in the evening. We got Facebook up in no time, a kid in his spare time.

Am I missing something here? Can anybody tell me how it is that much more complicated than that?

Mr. BERTONI. In the case of the IDES, what we found was it was a people issue. At each stage of the process, there is a workload. And let's just talk about ratings. To the extent that there aren't enough raters in play, that workload is going to back up. Medical exams, to the extent that there aren't enough medical examiners to handle the workload, and if we get a surge from a deployment on top of that, that work is going to back up. Yes, computers and automation can help leverage limited resources. But it has to be hand in hand with appropriate workload ratios.

Mr. FARENTHOLD. I understand that. But it seems like these are men and women that have put their lives on the line for our country. There is no way they are going to get discharged from the military before they see a doctor. That doctor ought to be able to make an initial assessment, and you all ought to trust your brother agen-

cy that is a good initial assessment, so they can get the money that they deserve to take care of their family as soon as they get out. Then you all can take as long as you want to do the second evaluation and say no. We have created too many steps and too much red tape to get that done.

Would you guys just do me a favor? When you finish, just stand out in the hall and work out the 10 steps that it takes to get this done and see how we can implement it. Forget the red tape, forget the standard, just do a block diagram on the back of a napkin and then hand it to some kid at Harvard and let him write it. It is simple, basic, undergrad computer science to get the technology to work. And I think you need to give your brother and sister agencies the benefit of the doubt.

I apologize for preaching more than I asked questions, but I am just appalled at the amount of time and the disservice we are doing to the men and women who have sacrificed life and limb for this country.

Thank you very much. I yield back.

Mr. CHAFFETZ. Thank you. The gentleman yields back.

We will now recognize the ranking member of the full committee, Mr. Cummings of Maryland for 5 minutes.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Let me go back to what I said in my opening statement. Mr. Tierney, I complimented you for back in 2007 grabbing hold of this issue. I was telling them about how we were at Walter Reed and what we saw back then. We have seen some improvement.

But one of the things I am most concerned about is I think that we may be accepting a normal that is simply inappropriate. And I don't know that we are dealing with what the President talks about on other issues, and that is the urgency of now. According to DOD and VA, under the original pilot program, the departments were able to meet their goals of reducing the average disability evaluation processing time for an active duty military below 295 days and reducing the average processing time for reservists to under 305 days. However, according to GAO, the average case processing time has steadily increased.

Let me say that this is simply unacceptable. I am very concerned about the rapid increase in the average processing time to complete the IDES system. They are now well above the initial goals of 295 and 305 days. It appears as if DOD and VA are unable to replicate the success of the pilot program as the IDES program has expanded to additional sites.

Mr. Medve, can you explain why this is the case?

Mr. MEDVE. Congressman, we have noticed an increase. That is why, as Secretary Shinseki looks at this, he feels very strongly that this is a leadership issue from the lowest level up to the top. That is why we have instituted reviews at all levels to understand what each site is facing in terms of challenges, what resources they might need, how we can get those resources to them. If there are people that need to be added or if there is equipment that needs to be sent there, as I stated before, we have now instituted very senior leader sessions between the VA and the Army to examine each one of these sites in detail.

Mr. CUMMINGS. When can we expect an answer with regard to the results of what you are talking about? We went out to Walter Reed, and I cannot get this man off of my mind. We went and we saw a gentleman, and I feel emotional just talking about it, where he had both of his legs blown off. And one of them, it was cut so high, up to about the waist, they basically had nothing to strap it onto.

And when I see people like that, and we talk about how much we love our veterans, how much we love our service members, we applaud what was just done by our Navy Seals and those brave men and women who resolved the issue of the last few days. And then it seems like suddenly we are talking about, we are going to meet, we are going to meet, we are going to meet. At some point, somebody has to say, wait a minute, these people are suffering now. Not yesterday, now. They have done their job.

So this constant thing of let's talk, let's talk, let's talk, that is fine. But when I see numbers increasing, that is a problem. It seems like alarm bells should go off everywhere. I think that is why Mr. Chaffetz, Mr. Tierney, are so concerned, and all of us are concerned about these issues. I am just wondering if we are all getting it.

So to constantly say, we are looking at it at the highest levels, this is the question: can you tell us when the chairman can bring you back before us with some answers to the questions that you just raised? In other words, why is this happening, how is it happening, how do we deal with it, so that we can get on with it. You know what I fear? I fear in 6 months we will be seeing the same stuff, and more people will have suffered.

So can you give us a date, Mr. Chairman, this is just something I think we need to do, to have you all come back and give us some real answers and show us some progress? Can you do that for us?

Mr. MEDVE. Mr. Chairman, I don't know if I can give you an exact date. I know that as we move out to——

Mr. CUMMINGS. Six months? How about 6 months? How about three?

Mr. MEDVE. Mr. Chairman, we will come back any time we are invited to——

Mr. CUMMINGS. No, no, you are not listening to me. What I am asking you to do is give us, I don't want us to have a hearing and then we come back and hear the same stuff. So if you tell me 3 months, I would suggest to the chairman, and he will do what he chooses, I understand, Mr. Chairman, I will give you 3½ if you say 3; if you say 2, I will say 2½. But we have to have answers, and we have to act on this with the urgency of now.

So how long will it take to get those questions answered that you just asked?

Mr. MEDVE. All I can tell you, Mr. Chairman, is that we are holding people accountable now to meet those standards and we are working toward getting to each of those sites to meet the standards.

Mr. CUMMINGS. Mr. Chairman, I thank you for your indulgence. I just think, Mr. Chairman, if you don't mind, and Mr. Ranking Member, I really think we have to set some deadlines. Because other than that, we will be hearing this over and over and over

again. I just hope that we can do that in a bipartisan way where we can get to the bottom of this.

Mr. TIERNEY. If the gentleman would yield, and if the chairman would allow me to make a statement on that? Thank you.

Look, I think we are maybe yelling at the wrong people on that. When we had the hearing out at Walter Reed, when this thing first broke, we wanted to hold people at the top accountable, not necessarily the people who are out there slugging away every trying to get these things done and taking the heat on that.

We had the hearing in March 2007. The Army Surgeon General, who was the top Army officer responsible for the failures out there, resigned. That was followed by the commander of Walter Reed, the Army Secretary, they resigned. And in July 2007, the Secretary of Veterans Affairs.

I suggest, Mr. Chairman, at the next hearing, we don't keep pestering this group of people who are out there working, trying to take orders. We kick it up a notch and we have some accountability for the people who are supposed to do this. We found out the Army Surgeon General lived across from Walter Reed, so he was a surgeon, he was a member of the services, and he was a neighbor, and hadn't visited. These things are just unacceptable.

And to keep forcing these folks, the good folks that come in front of us and explain what is going wrong, they can only do so much unless somebody at the top takes responsibility for working out these things. If a large part of it is personnel, then these folks aren't necessarily going to be able to make that decision. Somebody has to call to Congress' attention that we need X amount of dollars for the following personnel, they are to be assigned to the following locations and move it on.

So my respectful recommendation is that we consider bringing in folks at the top level decisionmaking thing and holding them responsible. I think the American people would have the same response, they will require some accountability on this.

Mr. CHAFFETZ. I would concur with both the ranking member and Mr. Cummings as well. While I appreciate the two people who have been here testifying today, it is an embarrassment to the Veterans Affairs, it is an embarrassment to the Department of Defense, to not send the most senior-most people to this committee. They owe these responses to the American people. I would hope we could work in a bipartisan way. If we have to issue subpoenas to get them here, we will issue subpoenas.

To have people come here who aren't even in the meeting on May 2nd, with all due respect, is an embarrassment to those two agencies. We need answers. This has gone on for years and years and years. And no longer will this committee put up with the tolerance of just saying, well, we are putting together and we are having meetings. It is not acceptable. It is absolutely not acceptable.

We will work together in a bipartisan way to make that happen. I totally concur with the comments that were just made here.

I would now like to recognize a member of our full committee, Ms. Buerkle from New York. She is also the chairman of the Veterans Affairs Subcommittee on Health. We will recognize her for a very lenient 5 minutes.

Ms. BUERKLE. Thank you very much, Mr. Chairman, and thank you for allowing me to participate in this hearing this morning.

I come here as the chairman of the Subcommittee on Health for Veterans Affairs, and I sit here this morning appalled at what I am hearing. As was echoed by my colleagues, we can't hold you accountable, but we can hold the Veterans Administration and DOD. This is shameful. This is absolutely shameful. Our men and women provide and protect us, and the very least we can do is, when they come home, we can provide them with the services and the health care that they need.

So I am trying to understand what happened here. In 2007, we identified problems. And then were there parallel systems? And now as of March there will be an integrated system? Am I understanding that correctly?

Mr. MEDVE. I think we had, what we termed a legacy Disability Evaluation System, which the DOD used to put the service member through who was going to be determined unfit. And then they were separated from the service. At that point then, they filed a claim with the VA. So they had a medical examination under DOD, they were separated, they came to the VA, and they went through another medical examination in order to get a rating.

What we have done since we have started both the pilot and now the full implementation is integrate both of those processes. So as a service member is identified as potentially being unfit for service, when they get into this process, they are then given one, we call it one medical exam, but it is composed of a number of them, because they may have a number of things, on the issues that make them unfit for continued service. At the same time, we also catalog all those things of which is service-connected for them. So we are doing all those examinations at one time.

Once those are done, then the record is sent to the VA for a disability rating for us, and at the same time sent to the DOD for an evaluation on the unfitting conditions. So that is happening now. But we still have a mixture of both legacy and the new system in place.

Ms. BUERKLE. So earlier, Mr. Bird, you testified that when a veteran downloads their medical record, they will at least get the pharmaceutical portion and then any other information that they may have entered into the system. Is that correct?

Mr. BIRD. That is correct.

Ms. BUERKLE. So we are then asking someone, their laboratory results aren't in there? Physical examination? Any examinations conducted by a physician? If they downloaded their medical records, all they are getting are those two components?

Mr. BIRD. Yes, that is correct.

Ms. BUERKLE. Does anybody realize how ineffective and inefficient that is? How that just doesn't work? We just had a vet here sitting in this committee download her medical records, Healthy Vet. And all she got when she downloaded her medical records was her name and address and anything she entered into that record. She didn't choose to enter her blood type in, so that didn't show up.

So it sounds to me like we haven't made a whole lot of progress. And what I hear from the veterans over and over and over again

is they can't get processed out. They are in such a hurry, because this process takes so long, they are in such a hurry that they just, they wash their hands of it and they just move on because they want to go spend time with their family and process out.

This isn't some theoretical problem we have here. This is very real. And I echo my trip to Walter Reed and to Bethesda and the suffering that these veterans are going through. The very least this Nation can do, the very least, is to get this process up and running and help them facilitate their discharge from their service to this country.

I was an attorney and represented a large teaching hospital. We integrated electronic medical records, the whole world is doing it. The Department of Defense and Veterans Affairs and Veterans Administration should be able to do it. We have the resources, you have bipartisan support that you don't get anywhere else. When it comes to our veterans and our military, there is bipartisan support.

There is no reason why we shouldn't be able to do this. I agree with my colleague, we need to set a timeframe, we need to get a time line. And I will echo what was said, we need to hold leadership responsible. I realize you folks are here just testifying. But we need to hold leadership responsible, because this is not theoretical, these are very real people, real veterans, and they are really suffering.

I yield back. Thank you, Mr. Chairman.

Mr. CHAFFETZ. Thank you. I appreciate that.

Let me make sure I have these numbers right. Processing was taking about 540 days. But I believe, Mr. Bertoni, you say that is now back up to 394? The goal was, I believe the number I wrote down during part of the testimony was 394 days is the average time.

Mr. BERTONI. Yes. Under the legacy system, they calculated a 540 day total processing time from referral to VA benefits. Right now, or as of March 31st, they are at 394 for active. If you are a marine, you are at 455 days. So these numbers are quickly closing in on the 540.

Mr. CHAFFETZ. How do you explain this? You have a family whose loved one has been serving overseas. It takes over a year to get them through the process and get them a check? What would you say to those veterans and their families? Ms. Simpson, go ahead.

Ms. SIMPSON. I don't think there is anything we could say that would make their situation better. I was not, I regret that I was not aware that the average time had gotten that high.

Mr. CHAFFETZ. How is that? That scares me unto itself. I appreciate your candor. I think you are right, I don't think there is an excuse any more. These reports that came out in 2004, then in 2007, then we are going to have a meeting. And I realize you are in the hot seat and it is much bigger and broader than just you. But you can understand why we are so infuriated. We are going backward at this point.

Mr. Medve.

Mr. MEDVE. Mr. Chairman, all I can tell you is, it is my responsibility, because I am part of the team to ensure that we are——

Mr. CHAFFETZ. Were you at the meeting on May 2nd?

Mr. MEDVE. I was.

Mr. CHAFFETZ. What was said? What were the conclusions?

Mr. MEDVE. The two topics they covered were IDES and electronic health records. And there is commitment by both Secretaries to improve IDES and to work toward a——

Mr. CHAFFETZ. So they sat down and said, we are committed to this, just like they had said before. There had to be some more detail or goals or particulars that came out of that meeting.

Mr. MEDVE. We have been charged with getting the system more efficient and effective and get——

Mr. CHAFFETZ. But that was the goal before, was it not? Come on, there had to be something new that came out of this. When is this thing going to work, fully work, like when can you say, this thing works?

Mr. MEDVE. Mr. Chairman, I can't give you a specific date.

Mr. CHAFFETZ. You are in a meeting with the Secretaries, we expect to hear an understanding of what the conclusion of that was. You have no specifics to share with us as to what was said?

Mr. MEDVE. Mr. Chairman——

Mr. CHAFFETZ. How long did the meeting last?

Mr. MEDVE. An hour.

Mr. CHAFFETZ. What specifics came out of that meeting? I have to believe that two Secretaries, in the midst of tackling Osama bin Laden, came up with some sort of conclusions and didn't just waste their time in this meeting.

Mr. MEDVE. Mr. Chairman, we are working toward getting this system for IDES as good as we can get it. That is the commitment.

Mr. CHAFFETZ. Now, one of the goals that the Secretaries put out is that they wanted to reducing the waiting time to 75 to 150 days. How in the world did they come up with that? We are still over a year and the number is sliding backward. How did they come to that conclusion?

Mr. MEDVE. Sir, that is an aspiration. We are looking closely at what we can actually achieve in terms of time. Embedded in this total time we do have appellate rights for the service members, we have transition——

Mr. CHAFFETZ. I didn't come up with the goal. They did. When would we expect, when can service men and women expect that we would meet the goal laid out by Secretaries Gates and Shinseki?

Mr. MEDVE. I can't give you a specific date, Mr. Chairman.

Mr. CHAFFETZ. Can you give me a year?

Mr. MEDVE. We are committed to come up with a recommendation——

Mr. CHAFFETZ. The answer is no, isn't it? The answer is no. And that's the frustration. You can't even tell me what year you think we are going to accomplish this. And as was pointed out here earlier—I am beyond words to understand why this is taking so long. We were chatting, and maybe one of the things we should do is, what if we went back and just photocopied the records and put them on 3 x 5 cards? Would that speed up the process at this point?

Mr. MEDVE. Mr. Chairman, if there is an impression that there aren't records, we——

Mr. CHAFFETZ. No, there are records. They just can't seem to talk to each other. We can't get them to go from the DOD to the VA.

Mr. MEDVE. We do have, when a service member transitions out to veteran standard, their electronic versions of what they have in their medical records are sent to a data warehouse that the VA can access, if you apply for——

Mr. CHAFFETZ. We will get through the minutiae. It scares me that you cannot even tell me what year you think we are going to get to these "aspirational" days. I think the servicemen and women are being misled in this understanding that this is accelerating, when the reality is, the numbers are getting worse. The wait times are getting worse. And we can't even, we have meetings with the Cabinet Secretaries that last for an hour, and they have aspirational goals, oh, it is going to get better.

Well, it is not getting better. And that is why we need more definitive answers.

I am over my time and will yield to the gentleman from Massachusetts, Mr. Tierney.

Mr. TIERNEY. Thank you. Before I forget, Mr. Chairman, may I ask unanimous consent that my opening statement be submitted into the record?

Mr. CHAFFETZ. Absolutely.

[The prepared statement of Hon. John F. Tierney follows:]

Opening Statement

Rep. John Tierney, Ranking Member

Subcommittee on National Security, Homeland Defense, and Foreign Operations
"Is This Any Way to Treat Our Troops? Part III: Transition Delays"

May 4, 2011

I want to thank all the witnesses for joining us today and also to thank Chairman Chaffetz for convening this hearing.

As many of you know, this Subcommittee has a long history of examining the care received by our wounded warriors. To those servicemen and women who have borne the battle, we owe nothing short of the very best care and treatment that our nation can provide.

Unfortunately, our nation has not always lived up to that important obligation. In 2007, the *Washington Post* revealed appalling conditions and unacceptable treatment of soldiers and their families at Walter Reed Army Medical Center.

Immediately following revelation of the poor conditions at Walter Reed, the Subcommittee held a series of hearings to critically examine what had gone so terribly wrong. In fact, the first hearing was held on the grounds of Walter Reed itself.

Less than a week after the Subcommittee's March 2007 hearing, the Army Surgeon General, who had been the top Army officer responsible for the failures at Walter Reed, resigned. This resignation was followed by that of the Commander of Walter Reed, the Army Secretary, and, in July 2007, the Secretary of Veterans Affairs.

Since then I've had the opportunity to visit Walter Reed on a number of occasions, including just three weeks ago with Chairman Chaffetz and Ranking Member Cummings. During my visit, I spoke with wounded warriors directly and asked them about the care they are receiving. Based on these visits and my conversations with the servicemembers I spoke with at Walter Reed, I am pleased to report that Walter Reed is now providing an extraordinary quality of care to our wounded warriors.

After viewing the new wounded warrior care facilities at the National Naval Medical Center campus in Bethesda, I feel confident that our injured soldiers, sailors, airmen, and Marines will continue to receive the same quality of care after the transition to the Bethesda campus in the Fall of this year.

As you know, the oversight hearings conducted by this Subcommittee also raised concerns about the bureaucratic and complex disability compensation system for wounded warriors. In response to these concerns, the President's Commission on Care for America's Returning Wounded Warriors, also known as the Dole-Shalala Commission, recommended completely restructuring the disability and compensation system for wounded soldiers. In particular the Commission recommended streamlining and simplifying the disability evaluation system.

In November 2007, the departments of Defense and Veterans Affairs launched a pilot integrated disability evaluation system. They claim that this new integrated system, also known as IDES, will shorten the processing time for wounded soldiers to complete the disability evaluation, eliminate any gap in benefits the soldier might experience and make the process less adversarial. Based on the success of the pilot program, this program is now being expanded to cover a total of 139 sites worldwide.

Unfortunately, significant challenges remain in achieving a seamless process for our servicemembers. For example, the departments of Defense and Veterans Affairs have stated that they would like to reduce the average processing time from the initial referral to the confirmation of VA benefits to 295 days. But, as the program has expanded beyond the initial pilot sites, the processing time has grown longer and longer. For Fiscal Year 2011, the average processing time for active duty servicemembers is now at 370 days and with a slightly shorter time of 360 days for reservists.

We've also heard concerns that the lack of sufficient staff has caused significant additional delays in some locations. In a report released this past December, GAO found that servicemembers at Fort Carson had to wait an average of 140 days to complete their medical exam, much longer than the Defense Department's goal of 45 days. Clearly, 140 days is an unacceptable amount of time for our wounded warriors to wait in order to complete a simple medical exam.

Finally, we've seen challenges in moving to a single medical exam and simplifying the disabilities rating process. I know firsthand this is one of the issues raised at our initial Walter Reed hearing in 2007. Although I understand the challenges in combining two arcane systems to a single streamlined process can be quite daunting, I strongly urge DOD and VA to work through these challenges for the sake of our nation's finest.

With that I look forward to hearing from our witnesses today and learning more about the challenges faced by our wounded servicemembers when they return from the battlefield. Thank you, Mr. Chairman.

Mr. TIERNEY. Thank you.

I would like to move on to how we are going to resolve this, if we can. Have we, and anybody that feels qualified can answer this, have we identified all of the technical problems that exist in this system, and have we identified all the personnel problems and whatever other problems are there? Do we know where the problems lie?

Mr. MEDVE. We have identified those areas resource-wise, facility-wise, and all, that we examine prior to any site going into the new process. We have actually held up sites because they either didn't have the right number of personnel or the right number of facilities. Because they weren't ready. So yes, I think we have——

Mr. TIERNEY. You think we know what the challenges are, and if we solve those challenges we will be doing better?

Mr. MEDVE. We know what the challenges are, and as we are moving forward with implementation, we are holding people to those standards, and we are not moving into it until they are read.

Mr. TIERNEY. So is there a plan for each of those areas, and how are you going to go bout solving the technology problems? How are you going to go about solving the personnel problems, whatever? Is there a large plan on that, an overlying plan?

Mr. MEDVE. Each site develops their own assessment. They develop their own concept plan of how to——

Mr. TIERNEY. But I would hope there is somebody a step up from that making sure that each site does that.

Mr. MEDVE. There are, absolutely.

Mr. TIERNEY. Who is responsible for that? Who is the ultimate go-to person that anybody would go to for an answer or to report the progress on each of these sites?

Mr. MEDVE. Each of these sites are briefed to both deputy secretaries in the Senior Oversight Council.

Mr. TIERNEY. And do those deputy secretaries have the final say in what software is used, what hardware is used, the numbers of personnel that are hired and where they are situated?

Mr. MEDVE. They don't get to that level of detail. Because each of the services in the VA has their responsibility.

Mr. TIERNEY. So you think the decisionmaking and all that steps a level lower than that?

Mr. MEDVE. Yes, in terms of the recommendations for that, what gets briefed to the deputy secretaries are, are you on target, do you have the number of resources——

Mr. TIERNEY. So it stops at the deputy secretaries, they know what the targets are and it is their responsibility to hold——

Mr. MEDVE. But I thought you were asking number of computers and that sort of thing.

Mr. TIERNEY. No, no, but I want the level of the person who says, have you solved this problem in hardware, have you solved this problem in software, have you got the right personnel in place, are we deciding whether it is cheaper to fly these people to a central location to get all the myriad physical and mental exams, or is it better to try to have that kind of personnel available at the site, those types of things, it is the deputy secretary level?

Mr. MEDVE. There is a brief during the SOC.

Mr. TIERNEY. And we think we have identified what the challenges are, that now just somebody has to monitor it for implementation and resolution?

Mr. MEDVE. Yes, sir, and that is where I think we are at now.

Mr. TIERNEY. And we know which services, which service branches, aren't doing as well as others, for instance, Air Force is not doing as well as Army?

Mr. MEDVE. Correct.

Mr. TIERNEY. One of the things that disturbed me in reading this was that when we didn't meet the goals, instead of deciding how we were going to meet them, we lowered the goal. I don't think that is the preferred path here, and I hope it is going to be reversed on that.

So if we really wanted an answer, instead of pounding at you and Ms. Simpson, it would be better to go to the deputy secretaries and find out just how much they are riding this. It seems to me if you really want to prioritize something, and you think this is the important thing, then a deputy secretary would be having a meeting every week, not every quarter or half year, but every week, asking the responsible people that report to them, just where are we on this and why aren't we further along. Does that sound reasonable, if we were to question those folks?

Mr. MEDVE. You can be assured that we are having those accountability meetings at a variety of levels currently.

Mr. TIERNEY. Do you have access to whatever kind of technical expertise you think you might need, in other words, outside computer analysts, computer specialists, computer entrepreneurs, whatever, are you able to resource those people and get them in to discuss with you some of the larger, more technical problems that you might be having challenges with?

Mr. MEDVE. I can't speak for our IT people, but we have set up workgroups to look at the technical challenges for the existing IT systems we have supporting this, to see where we can improve it.

Mr. TIERNEY. And those support groups go outside of just what we have in the Department of Defense and VA? We use other people as well?

Mr. MEDVE. I would assume so.

Mr. TIERNEY. What recommendations would you have for this committee in terms of, how can we best drill down on this and get ourselves an answer as to when we could expect this thing to be moving smoothly?

Mr. MEDVE. All I can tell you, Mr. Ranking Member, is that we are committed to implementing this through the rest of the fiscal year. As you know, each case takes a number of times. So in terms of getting more data, the sites we are bringing online now are at least, even if we hit our goal, 295 days down the line until we have any data in order to see if they are on target or off target with terms of the whole process. We can start to get glimpses in terms of how long it is taking to do the exams and those incremental pieces. But it does take a while.

Mr. TIERNEY. I understand the implications of each case and how sensitive that is. But Mr. Bertoni, do you get the feel that there is some sort of systematic approach to this, that somebody has an

overarching plan to get this resolve on the level of systems and plans as opposed to the individual cases?

Mr. BERTONI. I testified in December that I had not seen what I call a service delivery plan that puts all these pieces together.

Mr. TIERNEY. Exactly.

Mr. BERTONI. Would that be great for us to get our hands on and to assess? Absolutely.

Mr. TIERNEY. Who do you think would be responsible for doing that from your vantage point, when you look at what is being done and who is responsible for whatever over there, who would you look to for that?

Mr. BERTONI. I think there are some very talented people at VA and DOD that we have been working with that know this program, know the data. And those folks would be the people to do that.

Mr. TIERNEY. And who do they answer to?

Mr. BERTONI. Mr. Medve, for one. [Laughter.]

Mr. TIERNEY. OK, Mr. Medve. And who do you answer to?

Mr. MEDVE. Sir, I answer to the Assistant Secretary for Planning and Policy.

Mr. TIERNEY. The Assistant Secretary.

Mr. MEDVE. Yes, Assistant Secretary.

Mr. TIERNEY. And that person reports to the Deputy?

Mr. MEDVE. Yes, sir.

Mr. TIERNEY. Thank you all very much. I appreciate your testimony.

Mr. CHAFFETZ. Thank you. I would like to maybe just go down the row here, and just one last thing. I want to be very crystal clear, just the succinct, simple biggest problems and challenges that you see, and the recommendation or suggestion of what we need to have happen.

What I would like to do is start with Ms. Simpson and Mr. Medve, then go to Mr. Williamson, Mr. Bird and end on Mr. Bertoni, if we could, please.

Ms. SIMPSON. Thank you, Mr. Chairman.

My understanding is that the access to data, making sure that information is accurate, valid and succinct and that the metrics are held to, that is one thing. Second thing, to take a look at each of the sites, at each step in the process, and find out what specifically is going on to account for the length of time. I knew it was higher than 295, but I wasn't aware it was that high, that was just mentioned earlier.

And then the followup that is required to actually get to the place of the electronic health record, that we have very senior IT specialists who have reach-back capability to outside experts, outside the Federal Government, to be able to provide that foundation to use those records.

Mr. CHAFFETZ. Thank you.

Mr. MEDVE. Mr. Chairman, I would echo what Ms. Simpson said, in terms of the process. We are taking a hard look at ensuring that we have the requisite amount of medical personnel and outsourced personnel to do that. We are also monitoring that very closely to ensure that we have the required number. I am happy to come back again as we move through this implementation to show you how things are going and to brief the staff.

Mr. CHAFFETZ. Thank you.

Mr. Williamson.

Mr. WILLIAMSON. I would say from my standpoint, there are IT issues associated with the wounded warrior programs that would allow them to communicate and talk with one another. Without that, you are going to get confusion and consternation and conflicting kinds of recovery plans for our veterans and service members.

Mr. CHAFFETZ. How bad is the problem and how close are we to solving it?

Mr. WILLIAMSON. We are a ways away. There are some things that are going on right now in terms of the Federal Recovery Coordination program, that is a VA program, that requires DOD cooperation. It is the same thing you have been talking about throughout here.

Mr. CHAFFETZ. Thank you.

Mr. Bird.

Mr. BIRD. Developing large scale IT solutions is challenging enough for anybody. The Department of Defense has capabilities and VA has capabilities. They need to establish joint capabilities to tackle some of these large scale problems.

Mr. CHAFFETZ. Have they started that process?

Mr. BIRD. As I mentioned earlier, they started over 10 years ago. And they have frankly slowly been increasing their capabilities as well as increasing their capabilities to work together to tackle some of the challenges.

Mr. CHAFFETZ. But we are nowhere close to getting to the finish line?

Mr. BIRD. It is difficult to say, because the finish line has not yet been defined.

Mr. CHAFFETZ. Who should define that? Who should define the finish line?

Mr. BIRD. The department should define the finish line.

Mr. CHAFFETZ. The Secretaries, is what we need. That is encouraging.

Mr. Bertoni.

Mr. BERTONI. I think over the last several years, we have identified specific challenges I think that have impacted this program negatively. To DOD and VA's credit, I think they have tried to get in front of many of those. In particular, the issue of standing up sites, readiness, lookbacks, making sure that down the road, they are going to have appropriate staff in play.

Beyond that, I think there needs to be additional data collection at a more granular level. You need to know at particular site level locations, what are your ratios looking like? What are the problems with the diagnoses, problems with the exam summaries? Those are the things you need to know that are bogging the system down. Right now, that capability is not there.

So that is something that we definitely would see them do more granular data analysis and collection and monitoring, so they can make the adjustments. And this way, you could get in front of problems. You don't have to wait until you are 295 days down the road to say, we have a problem with ratings, we have a problem with exam summaries. But if you start to see this emerging, you

can make the adjustments, you can apply the training and you can apply the technology to get in front of those problems.

Mr. CHAFFETZ. Thank you. I want to thank you all for your participation. I know your heart is in the right spot in all these things.

It is terribly frustrating, it is terribly frustrating. These men and women, our American military does amazing things. We just saw that play out. But when it comes time, when they come home to take care of, we are failing. And it is about time that we at the Secretary level, at the Presidential level, that we get somebody who is irate who can actually move the ball forward and do some things to actually make this thing happen.

I know that members on this committee, I know Mr. Tierney has worked tirelessly on this. I will continue to pour my efforts into it. But we have to demand that we actually achieve these goals. That is going to take some serious leadership. I think that leadership is lacking within the highest levels with the Department of Defense and within the Veterans Administration.

I thank you all again for your information. You are pouring your hearts, like I said, in the right direction. We look forward, unfortunately, we will be having another one of these hearings again. But hopefully the news will be better and we will be making more progress.

Thank you again for your expertise and your testimony today. The committee stands adjourned.

[Whereupon, at 11:17 a.m., the committee was adjourned.]

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